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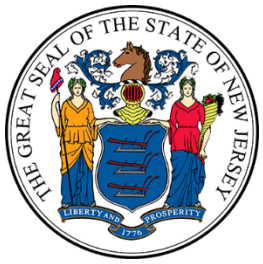

New Jersey State Health Innovation Plan

Prepared by Rutgers Center for State Health Policy

December 2017

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Acknowledgments

This State Health Innovation Plan (SHIP) was prepared under the NJ State Innovation Model (SIM) project. The work was supported by Funding Opportunity CMS-1G1-12-001 from the US Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) under Cooperative Agreement No. 1G1CMS331386-01-07, hereinafter referred to as New Jersey's State Innovation Model (SIM) Design grant. This report does not necessarily represent the official views of HHS, or any of its agencies.

This report was prepared by the Rutgers Center for State Health Policy, under the direction of Joel Cantor & Margaret Koller, on behalf of the State of New Jersey and reflects the intellectual content prepared by the NJ SIM project team. Specific acknowledgement is given to colleagues from the Rutgers Robert Wood Johnson Medical School Department of Family Medicine & Community Health including Alfred Tallia, Shawna Hudson, Jeanne Ferrante, Lynn Clemow, Maria Pellerano and Emily Panza. In addition, John Jacobi and Tara Ragone from the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law provided in depth legal analysis on the topic of behavioral health integration throughout this project and their work significantly informed this report. We would also like to thank Terry Shlimbaum for his leadership on the Delivery System Transformation Workgroup.

In addition, the entire NJ SIM project was made stronger by the input of the scores of stakeholders who attended our meetings and offered their voice to this design process. They reflect the diversity that is the hallmark of New Jersey and this Plan is richer for their input.

Finally, the development of this Innovation Plan was made possible as a result of the leadership and active engagement of a multi-agency Steering Committee that was chaired by the Governor's Office and included representatives from the NJ Department of Health and the New Jersey Department of Human Services' Division of Medical Assistance & Health Services (Medicaid) and Division of Mental Health & Addiction Services. Senior Policy Advisor Emily Baggett and Health Care Policy Advisor Robert Schwaneberg represented the Governor's Office on the SIM Steering Committee.

Related Publications:

In addition to this State Health Innovation Plan, New Jersey's State Innovation Model Design grant funded the research for and publication of numerous studies, including:

- Adams Ragone T. *Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers*.

Newark, NJ: Seton Hall University School of Law, Center for Health & Pharmaceutical Law & Policy, 2016. http://www.cshp.rutgers.edu/Downloads/10980.pdf.

- Thompson FJ, and JC Cantor. *The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process*. New Brunswick NJ: Rutgers Center for State Health Policy, 2016. http://www.cshp.rutgers.edu/Downloads/10950.pdf.
- Ahmad S, and D DeLia. *Tobacco Use in New Jersey: Variations by Socio-Demographic Characteristics, Region of the State, and Health Insurance Status*. Facts & Findings. New Brunswick, NJ: Rutgers Center for State Health Policy, 2016. http://cshp.rutgers.edu/Downloads/10930.pdf.

Information obtained during the course of the SIM project materially advanced the integration of physical and behavioral health care, one of the project's primary objectives. In particular:

- The New Jersey Primary Care Practice Survey summarized in Section 6 of this Plan was cited in Reorganization Plan No. 001-2017, "Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health," available online at: http://nj.gov/health/integratedhealth/documents/ReorgPlan.pdf.
- Pursuant to Reorganization Plan 001-2017, on Dec. 15, 2017, the Department of Health posted Guidance 1-2017 to facilitate the integration of outpatient care for physical, mental health and substance use disorder facilities licensed by the Department, available online at: http://nj.gov/health/healthfacilities/documents/CN/guidance/guidance_1_2017.pdf.

New Jersey State Health Innovation Plan

Executive Summary

In February 2015, under a cooperative agreement, the State of New Jersey was awarded a one-year, $3 million State Innovation Model (SIM) Design grant (No. 1G1CMS331386-01-07) from the Center for Medicare & Medicaid Innovation (CMMI). Major policy initiatives of Governor Chris Christie's administration which focused on implementing health system change, particularly with regard to the care and delivery of services to the state's 1.7 million Medicaid beneficiaries, were already well underway and served as the platform upon which the NJ SIM strategy was advanced. Rutgers Center for State Health Policy, in its capacity as an instrumentality of the State, served as the grant manager for this effort coordinating all project activities. The NJ SIM project team received a four-month extension, with all SIM-related activities completed by May 31, 2016.

The focus of the NJ SIM Design project was three-fold and included: 1) advancing behavioral and physical health integration strategies; 2) addressing Medicaid cost/value, especially for high-cost, complex patients; and 3) improving birth outcomes through smoking cessation efforts, especially among pregnant women. A series of analytic activities described throughout this State Health Innovation Plan (SHIP) was undertaken to achieve these goals.

The NJ SIM was overseen by a multi-agency Steering Committee charged with supporting the execution of the project activities, comprising leadership from the Office of the Governor, the NJ Department of Health (DOH), and the NJ Department of Human Services' (DHS) Division of Medical Assistance & Health Services (DMAHS)(Medicaid) and the Division of Mental Health & Addiction Services (DMHAS). Senior faculty from the Department of Family Medicine and Community Health at Rutgers Robert Wood Johnson Medical School also significantly contributed to this project.

Select Accomplishments under the NJ SIM

Stakeholder Engagement

The strategy for engaging cross-sector constituencies under the SIM leveraged New Jersey's rich history of outreach to stakeholders in the development and implementation of health policy in the state. Robust convening and consultation with stakeholders served as a

cornerstone of the NJ SIM, as demonstrated by the nearly 500 individuals and 162 organizations that in some way participated in SIM project activities.

Health System Design and Performance

The State's quality measurement and reporting strategies have been carefully developed to minimize provider reporting burdens and maximize validity and usability, but the recent and rapid advancement of value-driven system reforms has led to a proliferation of new reporting requirements, raising concerns about both the burden and effectiveness of reporting. An initial inventory of 786 metrics was identified and analyzed for frequency of use, meaningfulness, and usability and the process resulted in the development of a set of 31 "core" quality metrics that was presented to the State for consideration.

Value-Based Health Care Delivery and Payment Transformation

As part of the state's value-based health care and payment strategy, SIM resources were used to support critical Medicaid ACO activities including: (1) developing and initiating HIPAA-compliant data feeds; (2) refining the savings and quality measurement strategies using comprehensive Medicaid claims and managed care encounter data; (3) enhancing an existing Learning Collaborative; and (4) drawing on available public documents and interviews with ACO leadership to identify needs for implementation assistance and contribute to development of the evaluation and monitoring strategy. In addition, the State's FY 2017 budget also included a $3 million investment in the three certified Medicaid ACOs ($1 million each).

With ten Behavioral Health Homes (BHH) currently in place in four counties, and a new BHH Learning Community to support prospective BHHs which started in early 2017, the State's strong commitment to behavioral health integration and programs that support addiction recovery is evident. Sustainability efforts were further advanced by a $127 million increase in reimbursement rates for Medicaid behavioral health providers in the Governor's FY 2017 budget, which increased to $136 million in the FY 2018 budget. In September 2017, Gov. Christie committed $200 million across eight state departments to implement 25 initiatives to combat the opioid epidemic through prevention, treatment and recovery programs.

Delivery System Transformation

Implementation of the 2015 NJ Primary Care Practice Survey was completed among a statewide probability sample of 698 primary care providers. The Survey focused on: 1) value-based payment and delivery alternatives; 2) integration of behavioral health care with primary care services; and 3) availability of referral to smoking cessation services and the emerging role of e-cigarettes/vaping.

The results of this survey helped to inform major policy decisions, including:

- The transfer of Mental Health & Addiction Functions from the Department of Human Services to the Department of Health, and
- The statewide expansion of the Pediatric Behavioral Health Collaborative with an additional $5 million in state funding, which Governor Christie announced in January 2017.

Currently, there exist state-level regulatory and licensing challenges as well as provider reimbursement issues that need to be resolved before system-wide behavioral health integration can be achieved in a comprehensive way. An area of considerable focus for policymakers has been harmonizing the licensing and regulatory requirements, particularly with regard to treatment providers sharing patient health information. The project team produced an in-depth legal analysis[1] to: (1) identify and analyze the relevant federal and New Jersey laws that impact the sharing of patient health information among treatment providers; (2) document the challenges to health information sharing among treatment providers that relate to these legal requirements; and (3) explore opportunities to facilitate more successful exchange of treatment information for integration.

Population Health Improvement

Resources from the NJ SIM advanced the State's Population Health Improvement Plan, *Healthy New Jersey 2020 (HNJ2020)*, through robust and broad stakeholder engagement at six regional forums to collect input and assess progress toward specific population health improvement goals and milestones related to leading health indicators (LHIs) including: improving birth outcomes and childhood immunization rates, reducing the burden of chronic conditions such as heart disease and obesity, and increasing access to primary care. Overall, there were 170 participants in these meetings, representing 67 organizations and departments.

The University of Pennsylvania's Center for Health Incentives and Behavioral Economics (CHIBE) developed a program using incentive-based interventions to address smoking among pregnant Medicaid recipients and relapse-prevention among new mothers.[2] Colleagues at Penn found that, due to the success of incentives in improving health in a number of contexts, the use of financial incentives to promote health behaviors has been increasing in both the private and public sectors. This randomized control trial would implement two programs deploying

[1] Adams Ragone T. *Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers*. Newark, NJ: Seton Hall University School of Law, Center for Health & Pharmaceutical Law & Policy, 2016. http://www.cshp.rutgers.edu/Downloads/10980.pdf.
[2] Center for Health Incentives and Behavioral Economics. *Summary of Program of Financial Incentives for Smoking Cessation in Pregnant Woman*. Proposal developed under NJ SIM Design Grant (No. 1G1CMS331386-01-07), 2016.

different incentive structures to reduce cigarette smoking during and after pregnancy in the NJ Medicaid program.

Health Information Technology

New Jersey had three overarching health IT policy goals that, while pre-dating the SIM award, were advanced during the tenure of the SIM grant: 1) helping providers in large numbers make the transition to Electronic Health Records (EHRs); 2) continuing high-performing regional Health Information Organizations (HIOs); and 3) development of a statewide Health Information Network (HIN), which has since been implemented and will serve as a gateway to the nationwide HIN.

Sustainability Strategy

Moving forward, the project partners will look to sustain the momentum that was built under the NJ SIM with regard to delivery system transformation and population health improvement goals. The focus will be on the implementation of initiatives that are consistent with the State's strategy for improving the quality and efficiency of care delivery, particularly for New Jersey's most complex and vulnerable patients, while reducing avoidable costs.

Specifically, the continuation of New Jersey's Medicaid Comprehensive Waiver provides a timely opportunity to advance the behavioral health integration strategies that were informed under the NJ SIM. On July 27, 2017 the federal Centers for Medicare and Medicaid Services (CMS) extended the NJ FamilyCare 1115 Comprehensive Waiver through June 30, 2022. Included in this waiver is a framework to "move to a managed delivery system that integrates physical and behavioral health care." In addition, the relocation of Mental Health & Addiction Functions to the Department of Health pursuant to Reorganization Plan 001-2017 was intended to remove bureaucratic barriers impeding the integration of physical and behavioral health care. Pursuant to that Reorganization Plan, on Dec. 15, 2017, the Department of Health posted Guidance 1-2017[3] to "facilitate the integration of outpatient care for physical, mental health and substance use disorder facilities licensed by the Department."

[3] New Jersey Department of Health. "Guidance 1-2017: Integrated Health–Outpatient Licensure and Inspection." Accessed December 12, 2017. http://nj.gov/health/healthfacilities/documents/CN/guidance/guidance_1_2017.pdf.

New Jersey State Health Innovation Plan

Section 1: Introduction

New Jersey's State Innovation Model Design project was intended to build upon payment and delivery reforms already underway, particularly for the 1.7 million beneficiaries enrolled in NJ FamilyCare (Medicaid and the Children's Health Insurance Program [CHIP]). Foremost among these was the 1115 Medicaid Comprehensive Waiver, under which major changes occurred in the delivery of long-term services and supports, behavioral health services, programs for children and adults with developmental disabilities, and hospital engagement in population health improvement (through a Delivery System Reform Incentive Payment [DSRIP] program). The core tenets of this waiver have been extended through June of 2022 and will maintain a continued focus on managed behavioral health integration and coordination, further implementation of long-term services and supports programs for vulnerable populations, as well as other incentive-based activities that will promote high-value care for Medicaid beneficiaries. DSRIP has been extended through June 30, 2020, at which time it will transition to an alternative payment mechanism. It will be imperative that this new mechanism continues to advance the goal of improving population health by promoting and supporting the involvement of hospitals and hospital systems in community collaborations. On Oct. 31, 2017, CMS approved New Jersey's proposal to include a Substance Use Disorder Continuum of Care in its Comprehensive Waiver. This will allow NJ FamilyCare to expand its substance use disorder benefit package to include treatment services, including withdrawal management, in residential facilities that previously had been ineligible for Medicaid coverage under the Institution for Mental Disease (IMD) exclusion.

In addition, under Governor Christie's leadership, the three-year Medicaid Accountable Care Organization (ACO) demonstration project was launched with regional provider coalitions in Camden, Trenton, and Newark receiving state certification in July 2015. These ACOs are implementing care coordination and patient engagement initiatives that address both social and medical factors that influence health. The state was also expanding Behavioral Health Home (BHH) pilot initiatives for populations with serious behavioral and physical health needs. Together, these state-led initiatives provided a strong platform from which to successfully mount the 2015 NJ SIM Design project.

Overview of NJ SIM Design Strategy

In February 2015, under a cooperative agreement, the State of New Jersey was awarded a one-year, $3 million State Innovation Model (SIM) Design grant from the Center for Medicare & Medicaid Innovation (CMMI). Rutgers Center for State Health Policy, in its capacity as an instrumentality of the State, served as the grant manager coordinating all project activities. The NJ SIM project team received a four-month extension with all SIM-related activities completed by May 31, 2016.

The goals of the NJ SIM were to design payment and service delivery models to reduce Medicare, Medicaid, and CHIP program expenditures while preserving or enhancing quality of care. The focus of the NJ SIM was three-fold and included: 1) advancing behavioral and physical health integration strategies; 2) addressing Medicaid cost/value, especially for high-cost, complex patients and; 3) improving birth outcomes through smoking cessation efforts, particularly among pregnant women.

SIM project activities were organized broadly under nine core domains: (1) Population Health Improvement; (2) Health Care Delivery System Transformation; (3) Payment and/or Service Delivery Model; (4) Leveraging Regulatory Authority; (5) Health Information Technology; (6) Stakeholder Engagement; (7) Quality Metric Alignment; (8) Monitoring and Evaluation; and (9) Alignment with State and Federal Innovation.

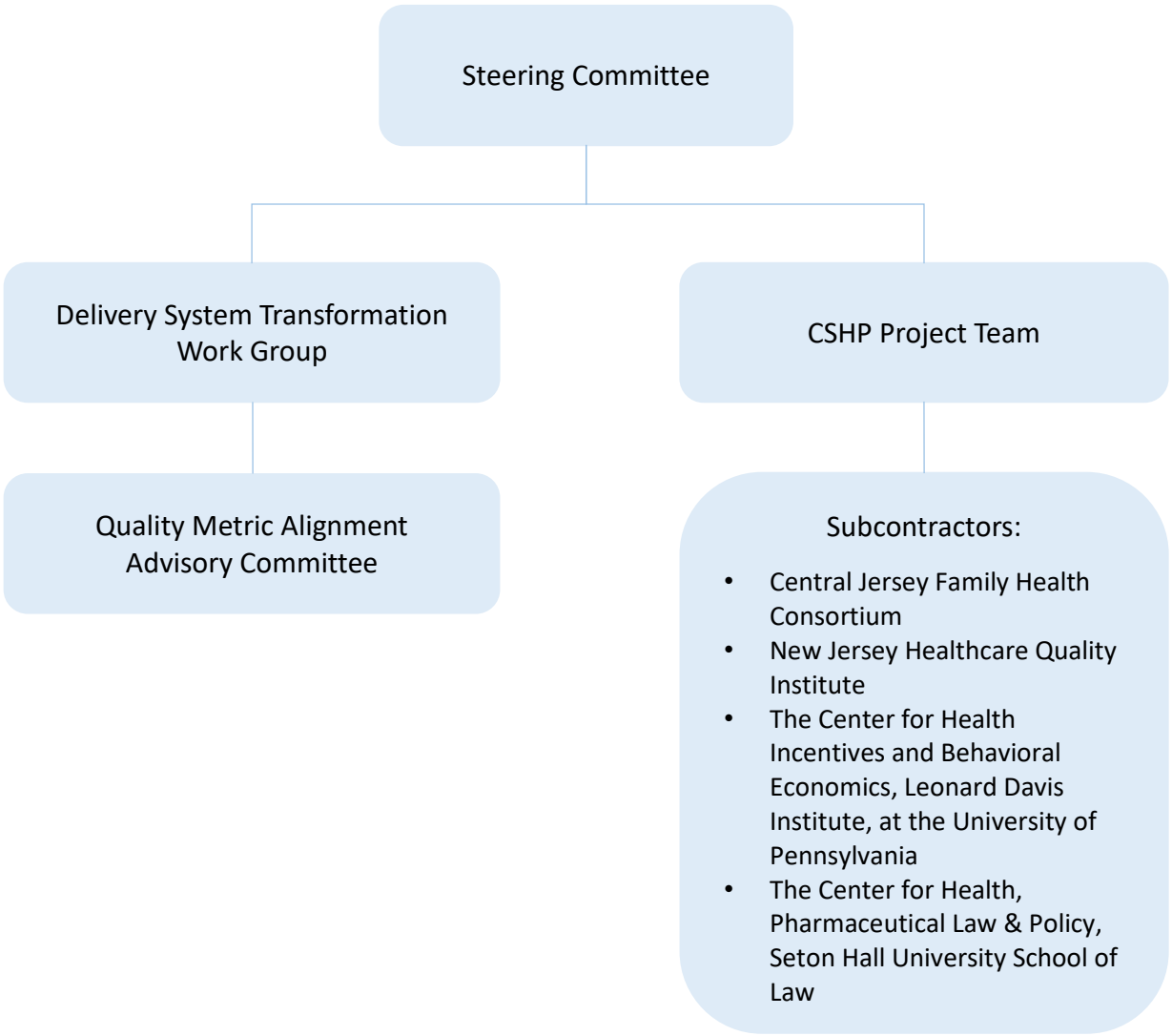
Foci of Activities

- Advance the implementation of *Healthy New Jersey 2020 (HNJ 2020)*, the State's Population Health Improvement Plan
- Conduct an environmental scan of the NJ health care delivery system, including a survey of primary care physicians
- Optimize the implementation of the Vital Information Platform (VIP) and coordination with health IT strategies
- Align quality metrics across payers and the delivery system to improve quality and reduce redundancy and avoidable costs
- Facilitate and inform implementation of the Medicaid ACOs
- Support Behavioral Health Home (BHH) pilot initiatives
- Design the Delivery System Transformation Resource Center to accelerate innovation efforts, particularly with regard to advancing patient-centered primary care strategies

Project Governance and Partnerships

The NJ SIM was overseen by a multi-agency Steering Committee charged with supporting the execution of the project activities, comprising leadership from the Office of the Governor, the NJ Department of Health (DOH), and the NJ Department of Human Services' (DHS) Division of Medical Assistance & Health Services (DMAHS)(Medicaid) and the Division of Mental Health & Addiction Services (DMHAS). Senior faculty from the Department of Family Medicine and Community Health at Rutgers Robert Wood Johnson Medical School also collaborated on this project and assumed a leadership role in the oversight and execution of the Delivery System Transformation Plan.

Governance Structure



Section 2: New Jersey's Health Care Environment

Characteristics of New Jersey's Delivery System

New Jersey is one of the most culturally and demographically diverse states in the nation, home to nine million residents including significant immigrant populations who speak a multitude of languages. According to the American Community Survey, New Jersey ranks third in the nation with regard to percentage of the population being foreign-born, with more than one-in-five (21%) residents being born outside of the United States.[4] While New Jersey's racial and ethnic diversity contributes to the state's uniqueness and prosperity, health care delivery and population health improvement initiatives can be more challenging as a result of our heterogeneity.

We know that physicians in New Jersey are more likely to be solo or small-group practitioners than in the rest of the country, which makes care coordination and implementation of electronic health systems and other program advancements challenging. In an effort to facilitate primary care transformation activities, during the SIM Project New Jersey was one of seven regions participating in the Comprehensive Primary Care initiative (CPCi) funded through the Center for Medicare & Medicaid Innovation (CMMI). In this demonstration, 72 high-performing primary care practices, four New Jersey payers, and various stakeholder groups came together to galvanize the primary care, patient-centered medical home model. New Jersey was also named as one of the 14 regions participating in CPC Plus, the successor initiative. While there have been many innovative efforts aimed at improving primary care practice delivery in New Jersey, we still see disproportionately high utilization of specialty care services throughout the state, which contributes to overall cost increases.

With regard to inpatient capacity, the most densely populated, northeastern region of the state has been found to have a surplus of hospital beds. However, fragmented ownership and the desire of communities to keep jobs and facilities nearby have resulted in minimal closures and downsizing. While for-profit hospitals are less prevalent in New Jersey than in the rest of the country, there has been a recent increase in the number of for-profit arrangements. The state has also seen significant movement in the direction of hospital system mergers. While these complexities and delivery system realities present challenges to the implementation of strategies to improve care and reduce cost, the NJ SIM provided the funding opportunity to leverage many exciting innovations and activities that were already underway in New Jersey.

[4] Grieco EM, YD Acosta, GP de la Cruz, C Gambino, T Gryn, LJ Larsen, EN Trevelyan, and NP Walters. *The Foreign-Born Population in the United States: 2010*. American Community Survey Reports. Washington, DC: U.S. Census Bureau, 2012. https://www.census.gov/prod/2012pubs/acs-19.pdf.

Overview of State Progress in Improving Health Systems

As detailed later in this report under the Population Health Improvement strategies (see Section 7), the NJ Department of Health (DOH), through the implementation of *Healthy New Jersey 2020*, is actively pursuing population health goals and engaging closely with stakeholder groups through regional convening and local grant programs. DOH is also leading the Delivery System Reform Incentive Payment (DSRIP) program component of New Jersey's 1115 Medicaid Comprehensive Waiver, the Hospital Relief Subsidy Fund, with a pay-for-performance/reporting system aimed at improving population health by addressing gaps in access, quality, and efficiency of care. The goals of the Comprehensive Waiver, which began in 2012 and has been extended through June 30, 2022,, are to: 1) expand managed care to cover long-term services and supports and behavioral health for specific populations; 2) expand home and community-based services to populations of kids/youth with autism spectrum disorder, intellectual, and developmental disabilities (IDD), and serious emotional disturbance; 3) establish a federally-funded supports program for individuals with IDD; and 4) streamline Medicaid eligibility determination and enrollment processes.

The Department of Human Services' (DHS) Division of Medical Assistance & Health Services (DMAHS) oversees the Medicaid program which currently provides benefits to over 1.7 million New Jersey residents (nearly 20% of the population) and has a $15 billion dollar budget, including state and federal matching funds. In recent years, New Jersey Medicaid has transitioned services away from traditional fee-for-service to managed care, with approximately 95% of Medicaid recipients enrolled in one of five participating managed care plans, enabling greater opportunity to achieve valued-based population health goals. One of the benefits of a managed care design strategy is that it facilitates the integration of long-term, acute, and behavioral health services, with the latter area being a primary focus under the NJ SIM Design project.

Other initiatives have been launched to streamline the state's health care delivery systems. DHS has certified three Medicaid Accountable Care Organizations (ACOs**)** in some of the state's most challenged urban communities (Newark, Trenton, and Camden) and is also working with a number of other Medicaid ACO "look-alikes" around the state to encourage comprehensive population health management, particularly for complex patients. With regard to Medicare, in 2016 over 1,500 New Jersey practices were participating in 29 Medicare Shared Savings Plans (MSSPs) around the state with more growth on the horizon. Finally, DMHAS oversaw the piloting of 10 behavioral health homes (BHH's) in four counties providing integrated care and case management for Medicaid enrollees who have been diagnosed with severe mental health conditions.

Health System Performance: State/Local Scorecards

The Commonwealth Fund has published several scorecards since 2009. These state scorecards rank the performance of all states on a broad array of domains including: 1) access and affordability of health insurance and care; 2) the frequency of recommended prevention and treatment activities; 3) potentially avoidable hospital use (ED, admissions, readmissions) and cost (reimbursements and premiums); 4) healthy lives (mortality amenable to health intervention, health behaviors, dental care, and body mass index averages); and 5) equity.[5]

According to the most recent, 2017 scorecard, New Jersey's best rank is in the area of "healthy lives" (9th in 2017) and its worst rank is in "avoidable hospital use and cost" (45th in 2015). NJ's rankings in other areas (access, prevention and treatment, and equity) show average performance compared to other states.

With 21 geographically and socioeconomically diverse counties in New Jersey, data, including findings from the Robert Wood Johnson Foundation's annual ranking of US counties on 33 health measures,[6] show marked regional differences. Among New Jersey counties, Cumberland, Atlantic, Salem, and Camden counties in the southern part and Essex and Passaic counties in the northern part of the state tend to fare worse in terms of health outcomes. Not unexpectedly, more affluent counties including Hunterdon, Morris, and Somerset counties in the north central/west corridors rank consistently high across all metrics.

Of the general indicators with trends in the most recent state scorecard, New Jersey improved on 41% of them and declined on approximately 3%. Specifically, improvements were seen in a number of key areas including uninsured adults and children, elderly patients receiving contraindicated prescriptions, and home health patients with improved mobility, the number of high-risk nursing home patients with pressure sores, Medicare 30-day hospital readmissions, short-stay nursing home residents with a 30-day hospital (re)admission, age-appropriate vaccinations (children and adults), adult smoking rates, adult obesity and deaths from colorectal cancer. The risk-adjusted 30-day mortality rate among Medicare beneficiaries hospitalized for heart attack, heart failure, pneumonia or stroke worsened.

Health System Performance: Dartmouth Atlas of Health Care (Medicare)

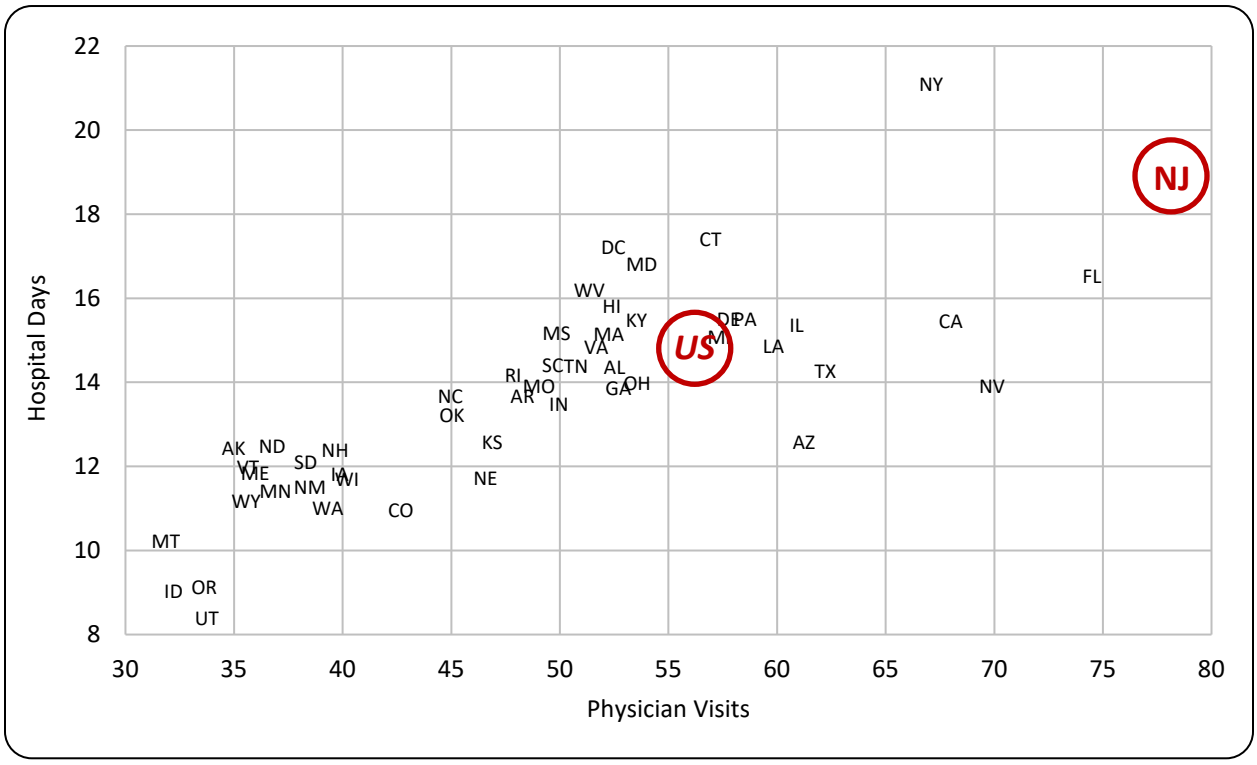
Among Medicare enrollees, New Jersey had the 6th lowest total mortality overall in 2014 (adjusted for age, sex, and race). While this is good news, an examination of patterns of care

[5] Commonwealth Fund. "Health System Scorecards." Accessed December 12, 2017. http://www.commonwealthfund.org/publications/health-system-scorecards.
[6] Robert Wood Johnson Foundation. "County Health Rankings & Roadmaps." Accessed December 12, 2017. http://www.rwjf.org/en/how-we-work/grants/grantees/county-health-ranking-roadmap.html.

among Medicare recipients in New Jersey relative to other states suggests over-utilization of high-intensity care involving medical specialists and hospital care with less emphasis on preventive primary care and low-intensity end-of-life care such as home health and hospice. While the experiences of Medicare enrollees are clearly important, care patterns may differ for populations covered by other payers.

Figure 1 shows that, compared to other states, New Jersey Medicare enrollees (who died in 2013) had the highest number of physician visits during the last two years of life (39% higher than the US average) and second-highest number of hospital days (28% higher than the US average). Indeed, on the composite measure of hospital care intensity (i.e., combining inpatient days and inpatient visits), New Jersey was the highest in the country in 2013. As New Jersey ranked 46th on Medicare hospital readmissions according to the Commonwealth Fund scorecard, the higher intensity is not translating to better care.

Figure 1: Hospital Days and Physician Visits per Medicare Decedent in Last 2 Years of Life (2013 Deaths)

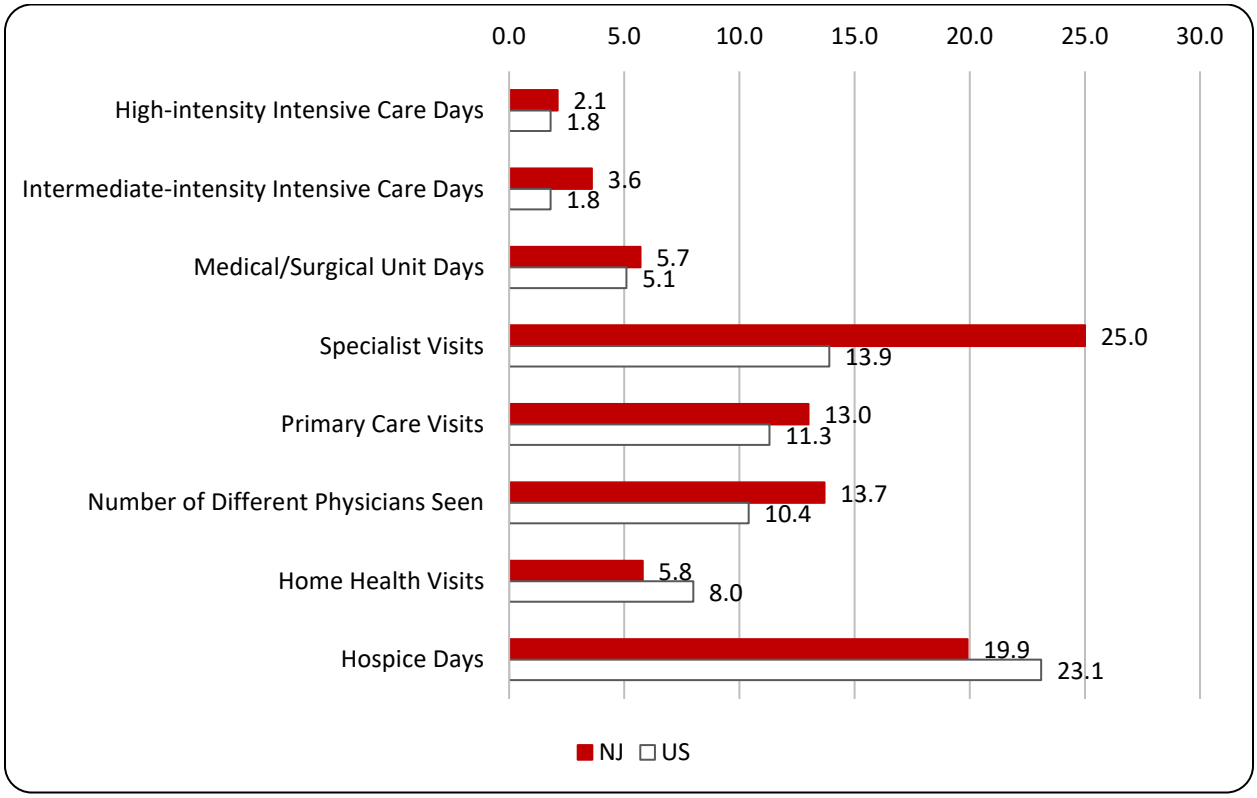


Source: Dartmouth Atlas of Health Care, 2013.

Figure 2 shows differences in Medicare patient experiences in the last six months of life between New Jersey and the US average. New Jersey stands out because of its high intensity of physician visits (highest of all states), particularly medical specialists (highest of all states—80%

higher than the US average). New Jersey lags the US average in lower-intensity services such as home health visits (28% below the US average) and hospice days (14% below the US average). With regard to primary care measures, New Jersey is close to the national average for Medicare enrollees on process measures such as primary care visits and preventive testing, but lagging with respect to discharges for ambulatory-sensitive conditions and with a larger disparity between black and white residents than the national average (data not shown).

Figure 2: Medicare Patient Experience in Last 6 Months of Life, 2013 Decedents



Source: Dartmouth Atlas of Health Care, 2013.

While the progress of New Jersey's innovations is evident in many areas including the advancement of value-based Medicaid initiatives, there is still opportunity for system-wide improvements. As this State Health Innovation Plan details the accomplishments under the NJ SIM Design Award and the strategies for future implementation, one of the keys to sustained progress will be continued broad stakeholder engagement and alignment of efforts across public and private sectors as well as coordination between the Medicaid and Medicare programs.

Section 3: Stakeholder Engagement

The strategy for engaging cross-sector constituencies under the SIM builds on New Jersey's rich history of outreach to stakeholders in the development and implementation of health policy in the state. Robust convening and consultation with stakeholders served as a cornerstone of the NJ SIM, as demonstrated by the nearly 500 individuals and 162 organizations that in some way participated in SIM project activities. The plan for collecting public input was twofold. First, Rutgers Center for State Health Policy (CSHP), with a depth of experience in bringing together disparate groups to facilitate the achievement of common goals, would leverage the expertise found on existing committees convened under the state's authority. Second, as CSHP identified the need for further input or where these committees lacked sufficient breadth and expertise, additional stakeholder engagement was conducted.

Tapping into Standing State Committee Expertise

Two long-standing state advisory bodies informed the decision-making and the work products produced under the NJ SIM.

The Quality Improvement Advisory Committee (QIAC) advises the NJ DOH on health care quality improvement and performance monitoring initiatives. Among the 25 members of the QIAC, including Professor Joel Cantor, Director of Rutgers CSHP and Principal Investigator for NJ's SIM project, are NJ's most knowledgeable experts in health quality measurement and improvement as well as leading representatives of the full range of stakeholder perspectives. They include representatives from hospitals, health centers, physicians, nurses, other providers, health insurance plans, business, labor unions, consumer/patient groups, academia, and other relevant state agencies. Interested members of the QIAC formed the core of the NJ SIM *Quality Metric Alignment Advisory Committee,* and the membership was enhanced to include additional representatives from Medicaid Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs) when the state's metric alignment strategy began to focus on the convergence of metric reporting for these two groups. The *Quality Metric Alignment Committee* was convened four times and offered input into the design of the proposed core set of metrics developed by the NJ HealthCare Quality Institute ("Quality Institute"), well-regarded quality experts in the state and a subcontractor under the NJ SIM (see Section 4, "Health System Design & Performance Objectives," for detailed information on the metric alignment activities).

The Medical Assistance Advisory Council (MAAC) was established as required under federal and state law to advise the NJ Medicaid director about program policy decisions affecting beneficiaries and to foster communication with the public. MAAC membership includes

representatives of consumers and patients, service providers, and Medicaid managed care organizations. Faculty and staff from CSHP frequently participate in the MAAC meetings as the Center is currently serving as the evaluator for the NJ Comprehensive Medicaid Waiver and staff brief the Council on relevant developments and cross-cutting Medicaid activities under the SIM. In addition, the MAAC is chaired by Deborah Spitalnik, PhD, Executive Director of the Boggs Center on Developmental Disabilities and a Professor of Pediatrics at Rutgers Robert Wood Johnson Medical School. Dr. Spitalnik is also a member of CSHP's External Advisory Committee (EAC) and was specifically consulted on the design of the metric alignment strategy to assure that quality measures relevant to the very important developmentally and intellectually disabled populations were appropriately considered.

Although the above-referenced standing committees served as initial access points to many stakeholder constituencies, one additional standing body was created under the auspices of the NJ SIM specifically related to tasks of aligning and coordinating delivery system transformation across payers and the full spectrum of care. The *Delivery System Transformation Workgroup (DSTW)* convened monthly for the duration of the SIM Design Model activities. The DSTW leadership included Bob Schwaneberg, Governor Chris Christie's Policy Advisor for Health Care, representatives from the Center for State Health Policy, the Rutgers Robert Wood Johnson Medical School's Department of Family Medicine and Community Health, and Seton Hall University School of Law's Center on Health and Pharmaceutical Law and Policy. The leadership group was chaired by Terry Shlimbaum, MD, an expert in primary care transformation and clinical practice in New Jersey.

Finally, the Center for State Health Policy leveraged opportunities to engage with stakeholder groups through its participation on other CMMI-funded initiatives, specifically the Comprehensive Primary Care initiative's (now referred to as "CPC Classic") multi-stakeholder group. The strategy was to penetrate siloes and harmonize communication about delivery system reform progress, writ large, across the broadest constituencies possible in New Jersey. An example of that shared learning occurred when leadership from the CSHP SIM project team presented findings from the NJ Primary Care Practice Survey (PCP) at the spring CPC Classic Regional Learning Meeting.

Convening and Gathering Stakeholder Input under the NJ SIM

As noted above, the NJ SIM's stakeholder engagement strategy was multi-pronged (see Table 1 for a summary of all mechanisms through which stakeholder input was collected). In addition to reaching out to standing groups, the project team successfully convened groups on multiple occasions for specific purposes, including two statewide invitational summits.

The first meeting, entitled *Paving the Way to Higher Performing Healthcare in NJ,* took place in June 2015. In addition to funding under the SIM Design Model award, further support for this event was provided by two important philanthropies, the Robert Wood Johnson Foundation and The Nicholson Foundation. The summit was attended by 114 individuals that included representation from agencies within NJ government and cross-sector stakeholder organizations including providers, payers, consumer advocates, funders, unions, policy experts, and academics. The goal of the meeting (see agenda in Appendix B) was to highlight the delivery system transformation and value-based payment reforms that were currently underway in New Jersey and identify opportunities to advance that work under the SIM Design Model. With an esteemed group of panelists and presenters, including keynote speaker Dr. Paul Grundy, Founding President, Patient-Centered Primary Care Collaborative & Global Director of Healthcare Transformation at IBM, the day concluded with a post-meeting evaluation for participants to solicit input to inform subsequent convening events. Recommendations for a future meeting included further discussion on behavioral health integration strategies (one of the core priorities of the NJ SIM) and learning from best practices gleaned from other states. Lastly, the feedback suggested expanding the constituencies "under the tent" at future meetings to include FQHCs, HIT experts, and paraprofessional groups burgeoning under the redesigned healthcare workforce schema (e.g., community health workers).

The second statewide summit was hosted in November 2015 and focused on *Advancing Delivery System Transformation in NJ* (see agenda in Appendix B). As with the previously held meeting, support for this event was enhanced by funding from The Nicholson and Robert Wood Johnson Foundations. Nearly 170 stakeholders across a broad array of groups participated in this meeting. Responding to the feedback provided in the June meeting evaluations, this summit featured greater emphasis on topic-specific breakout sessions. Stakeholders engaged in rich panel discussions around: 1) behavioral health integration; 2) care coordination priorities for vulnerable populations; and 3) building a healthcare workforce to advance delivery system transformation. We learned from the evaluations from this meeting that there was still a strong desire among participants to gain insights into delivery system transformation activities undertaken in other SIM Design Model states, particularly those that track closely with the demographics and delivery system landscape in New Jersey. In addition, there was keen interest in advancing the goals of quality metric alignment and exploring legal considerations that influence the ability to coordinate care and exchange patient information between and among clinical providers.

Lastly, the belief that all SIM activities were enriched by broad stakeholder input anchored the decision to host regional meetings to assess the progress toward meeting the goals of *Healthy New Jersey 2020*, the state's Population Health Improvement Plan. During the Fall 2015,

working closely with leadership from the NJ Department of Health, the SIM project team hosted six regional forums on three topics aligned with HNJ 2020 priorities including: 1) improving birth outcomes (with a special focus on programs aimed at smoking cessation among pregnant women) and childhood immunization rates; 2) reducing the burden of chronic conditions such as heart disease & obesity; and 3) access to primary care. At the conclusion of this DOH-led "listening tour", over 170 stakeholders representing 67 organizations and public health departments participated in these conversations which served to inform decisions around program acceleration and areas where course correction and redirection of DOH resources was necessary.

Table 1: Stakeholder Engagement at a Glance

Mechanism for Engagement	Cross-cutting Domains	Stakeholder Group Focus
Six Regional Meetings	- Population Health Improvement - Stakeholder Engagement	- DOH grantees - Community organizations - Local public health depts.
Two Statewide Summits	- Value-based Purchasing - Delivery System Reform - Health System Design & Improvement - Stakeholder Engagement	- Providers (physicians and hospitals) - Payers - Consumers - Unions - Employers - Policymakers - Academics/thought leaders
Key Informant Interviews - Medicaid ACOs - Medicare ACOs - Privacy and data sharing analysis	- Value-based Purchasing - Delivery System Transformation - Stakeholder Engagement	- Community organizations - Providers - Payers - Academics/legal scholars
Primary Care Provider Survey	- Delivery System Transformation - Stakeholder Engagement	- Primary care providers
CPC Classic Multi-Stakeholder/Regional Learning Meeting	- Delivery System Transformation - Stakeholder Engagement	- Providers - Payers
Delivery System Transformation Work Group (DSTW)	- Delivery System Transformation	- Providers - Policymakers - Academics
QIAC / Quality Metric Alignment Advisory Committee	- Health System Design & Performance Improvement - Stakeholder Engagement	- Providers (hospitals and physicians) - Payers - Consumers - Quality Improvement experts - Academics
Medical Assistance Advisory Council (MAAC)	- Value-based Purchasing - Stakeholder Engagement	- Medicaid managed care organizations (MCOs) - Consumers - Providers

Section 4: Health System Design and Performance Objectives

Quality Measurement and Reporting Overview

New Jersey has consistently been at the forefront of healthcare quality measurement and public reporting. The NJ Department of Health regularly prepares and disseminates quality summaries across the care spectrum through reports and web-based tools measuring hospital performance, healthcare-associated infections, patient safety, cardiac procedures, stroke services, hospital and nursing home staffing, and other areas. Further, the NJ Department of Banking & Insurance routinely publishes quality reports on health maintenance organizations, and the NJ Department of Human Services monitors and reports on Medicaid health plan performance, benchmarking quality metrics against nationwide averages.

The state's quality measurement and reporting strategies have been carefully developed to minimize provider reporting burdens and maximize validity and usability, but the recent and rapid advancement of value-driven system reforms has led to a proliferation of new reporting requirements and raised concerns about both the burden and effectiveness of reporting**.** During the SIM Project, for example, the NJ Delivery System Reform Incentive Payment (DSRIP) program required hospitals to gather and report 98 performance measures (since reduced to 83), the NJ Medicaid ACO demonstration required reporting of 27 measures, the Medicare Shared Savings Program required 33 metrics, and programs such as the Medicare Physician Quality Reporting System and other initiatives were adding still more reporting demands.

The NJ SIM Quality Measure Alignment strategy proceeded in three stages. First, the Quality Metric Alignment Advisory Committee (see Appendix A for Committee roster), with membership drawn from the state's already constituted Quality Improvement Advisory Committee (QIAC), established priorities for quality metric review based on four considerations: (1) the relative importance for value-based system improvement; (2) the degree to which reporting requirements vary across payers; (3) metrics where reporting burden might outweigh their importance; and (4) where other opportunities to streamline measurement and reporting may exist.

Second, with this strategy in place and a mechanism for broad stakeholder input identified, the NJ Health Care Quality Institute ("Quality Institute"), national experts in the areas of health care quality, measurement, and safety and a subcontractor on the SIM project team, moved forward with a comprehensive metric review and alignment analysis. The charge was to eliminate duplicative, poorly constructed, or insufficiently valuable measures, promote common measurement specifications, and effectuate other efficiencies in data collection and reporting. This work culminated in the development of a set of 31 "core" metrics (see Table 2).

Developing a Quality Metric Alignment Strategy

The Quality Institute partnered with Applied Medical Software (AMS) to develop a harmonized set of core quality metrics that would support alignment across the breadth of public and private quality improvement initiatives.

The process that the team from the Quality Institute and AMS employed to arrive at the aligned set of metrics was comprehensive and rigorous and included the following five steps:

1. Identify the various state and federal quality and efficiency improvement initiatives
2. Create an inventory of metrics required under each initiative
3. De-duplicate the list of metrics and identify the most commonly used metrics
4. Determine metric meaningfulness
5. Determine metric usability

The initial list of initiatives that were selected for analysis by the Quality Metrics Alignment Advisory Committee intersected with SIM-related initiatives including the DSRIP, the NJ Medicaid ACO Demonstration Project, NJ's Behavioral Health Home initiative, and NJ's Medicaid MCO contract. Those initiatives proved to be a sound starting point, but the intention was always for the Quality Institute and AMS to survey the broadest program landscape as possible. Given the limited time available for this analysis, the Quality Institute and AMS focused their efforts primarily on outpatient measures rather than on inpatient hospital quality measures. Therefore, patient safety measures such as pressure ulcers, falls, and hospital-acquired infections, were classified as inpatient (and therefore not considered), while measures such as medication reconciliation post-discharge and childhood immunization status were classified as outpatient.

The additional programs that were considered were identified both through on-line searches and review based on input from assorted stakeholders who were engaged in the process. In total, 18 quality and efficiency improvement initiatives were reviewed for this analysis, including:

- AHRQ Prevention Quality Indicators
- Behavioral Health Homes
- CMS-AHIP ACO Metrics
- CMS-AHIP Patient-centered Medical Home Metrics
- Delivery System Reform Incentive Payment (DSRIP)
- Electronic Health Record Incentive Program
- Core Set of Health Care Quality Measures for Medicaid Health Home Programs
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Leapfrog Hospital Survey

- NJ Innovation Institute PTN Project
- NJ Medicaid MCO Contract
- 2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)
- 2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)
- NJ Medicaid ACO Demonstration Project
- Physician Consortium for Performance Improvement® (PCPI™)
- Physician Quality Reporting System (PQRS)
- CMS Performance-based Incentive Program (MIPS)
- CT Healthcare Innovation Plan (SIM) Core Measure Set

The analysis of these 18 initiatives produced an initial list of 786 measures, which were then de-duplicated and, where appropriate, like or closely similar measures were consolidated. This wave of review winnowed the list down to 737 measures.

The next step in the alignment process was to target measures that are used frequently across initiatives with a threshold of five or more initiatives established as the next cut-off. This refinement produced a list of 30 metrics, with one additional metric, 30-day all-cause readmission rate, added to the list at the request of the SIM Quality Metric Alignment Advisory Committee and because the large number of disease-specific readmission rate metrics (e.g., readmission rate for heart failure, AMI or, pneumonia) that appeared in the inventory but did not meet the 5-initiative threshold independently would have done so as a combined set of readmission rate metrics.

With this preliminary list narrowed dramatically, a further screening for the meaningfulness and usability of the measures was undertaken by the project team. Meaningfulness was defined as whether the metrics being monitored accurately reflect the impact on care that an entity has achieved. Using the National Quality Strategy developed by the Agency for Healthcare Research and Quality (AHRQ), six priorities were considered including: 1) making care safer by reducing harm caused in the delivery of care; 2) ensuring that each person and family is engaged as partners in their care; 3) promoting effective communication and coordination of care; 4) promoting the most effective prevention and treatment practices for the leading causes of mortality; 5) working with communities to promote wide use of best practices to enable healthy living; and 6) making quality care more affordable for individuals, families, employers, and government.

Each of the 31 metrics was assigned to a category representing one of these 6 priorities, and then grouped by target population: i.e., adult (39%), adult/pediatrics (42%), or pediatric only

(19%). This step was undertaken to assure that harmonized list of measures monitored care across the life span.

After meaningfulness was established, the next step in this analysis explored whether benchmarks exist that reporting entities could use in order to assess their performance on specific standards. This speaks to the usability of the metrics that allow organizations to judge their performance against an external source. Benchmarks were found for each of the 31 metrics, and included the following reference sources:

- Healthy People 2020
- National Committee for Quality Assurance (NCQA)
- Healthy NJ 2020
- Agency for Healthcare Research & Quality (AHRQ)
- Child and Adolescent Health Measurement Initiative
- American Psychiatric Association – Physician Consortium for Performance Improvement
- Institute for Clinical Systems Improvement
- National Center for Health Statistics

The final step in this exhaustive process was to categorize the measures as either process (n=16) or outcome (n=15), using the definition from the Agency for Healthcare Research and Quality (AHRQ) and the Patient Safety – Quality Improvement Program of the Duke University School of Medicine/ Department of Community and Family Medicine.[7]

Next Steps

The project team presented the final set of 31 harmonized metrics first to the Quality Metric Alignment Advisory Committee, then to the SIM Steering Committee, and finally to relevant governing state authorities for their consideration. Moving forward, the Quality Institute will continue to monitor the list that they developed and make adjustments as quality reporting strategies continue to evolve and take shape in this dynamic environment. They stand ready to collaborate with both public and private entities to identify the most appropriate opportunities to advance this alignment strategy.

[7] Process measures assess activities carried out by health providers to deliver services. Outcome measures assess the final product or results. See Department of Community and Family Medicine, Duke University School of Medicine. "Measurement: Process and Outcome Indicators." Accessed April 20, 2016. http://patientsafetyed.duhs.duke.edu/module_a/measurement/measurement.html; and Agency for Healthcare Research and Quality. "National Quality Measures Clearinghouse." Accessed April 20, 2016. https://www.qualitymeasures.ahrq.gov/tutorial/ProcessMeasure.aspx.

Table 2: Core List of Harmonized Metrics

Measure	Total Programs	NQF Focus	Target Population	Source of Data	Process vs Outcome
Ambulatory Care – Emergency Department (ED) Visits (AMB) / rate and/or preventable	5	Affordable	A/P	O	O
CAHPS (Appointments, How Well Providers Communicate with Patients; and Access to Specialists)	5	Coordination	A/P	O	O
Medication Reconciliation Post-Discharge (see NQF 554)	5	Coordination	A/P	B	P
30 Day All Cause Readmission Rate	4	Coordination	A/P	B	O
Follow-up After Hospitalization for Mental Illness (FUH)	9	Partners	A	B	P
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	8	Pop Health	P	C	P
Childhood Immunization Status	7	Pop Health	P	B	P
Prenatal & Postpartum Care: Postpartum Care Rate (PPC)	7	Pop Health	A	B	O
Depression Remission at Twelve Months	6	Pop Health	A/P	C	O
Immunizations for Adolescents	6	Pop Health	P	B	P
PC-01 Elective Delivery : (Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed)	6	Pop Health	A	C	O
Well-Child Visits in the First 15 Months of Life	6	Pop Health	P	B	O
Adolescent Well-Care Visit (AWC)	5	Pop Health	P	B	O
Controlling High Blood Pressure	12	Rx	A	B	P
Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing	8	Rx	A/P	B	P
Diabetes: Hemoglobin A1c Poor Control	7	Rx	A/P	C	O
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	7	Rx	A	C	P
Medication Management for People with Asthma	7	Rx	A/P	C	P
ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	6	Rx	P	B	O
Anti-Depressant Medication Management	6	Rx	A/P	B	P
Diabetes: Eye Exam	6	Rx	A/P	B	P
Diabetes: Medical Attention for Nephropathy	6	Rx	A/P	B	P
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	5	Rx	A	O	P
Use of Imaging Studies for Low Back Pain	5	Safety	A	B	P
Cervical Cancer Screening	10	Screen	A	B	O
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	10	Screen	A	C	O
Chlamydia Screening for Women	8	Screen	A	B	O
Breast Cancer Screening (See NQF 31)	7	Screen	A	B	O
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	7	Screen	A/P	C	P
Colorectal Cancer Screening	6	Screen	A	B	O
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	5	Screen	A/P	O	P
			A = Adult A/P = Adult/Peds P = Peds	B = Billing C = Chart O = Other	P = Process O = Outcome

NQF Focus

Affordable - Making quality care more affordable
Coordination - Promoting effective communication and coordination
Partners - Ensuring people/families engaged in care
Pop Health - Promoting wide spread use of best practices to promote healthy living
Rx - Effective prevention and treatment practices
Safety - Reducing harm
Effective Screening

Source: New Jersey Health Care Quality Institute.

Section 5: Innovations to Achieve Value-Based Health Care Delivery and Payment Transformation

New Jersey's recent policy initiatives have been aimed at transforming care for complex, high-cost patients, with an emphasis on those living in low-income, vulnerable communities. Two major state initiatives served as the foundation for advancing the NJ SIM value-based health care delivery and payment transformation strategy. First, since mid-2015 the NJ Medicaid ACO demonstration has brought population-based accountable care to approximately a quarter million beneficiaries. Second, a BHH initiative has created integrated delivery systems for children and adults with severe behavioral and co-occurring physical health problems.

Medicaid ACOs

About the Medicaid ACO Demonstration

The Medicaid ACO demonstration project, enacted in August 2011 (NJ P.L. 2011, c.114), certified three regional coalitions of providers in Newark, Camden, and Trenton in July 2015 to share Medicaid savings they generate through improved care coordination and other strategies, subject to meeting quality standards.[8] The ACOs are accountable for 21 core quality measures in six domains: prevention, acute care, behavioral health, chronic conditions, utilization, and patient experiences, and must select six additional prevention and chronic care measures from a list of 39.[9]

As a population-based initiative, the NJ Medicaid ACO demonstration project further aligns with other goals of the NJ SIM including the advancement of the state's Population Health Improvement Plan, *Healthy New Jersey 2020,* overseen by the NJ Department of Health. Certified ACOs are accountable for spending and quality among all Medicaid enrollees within designated ACO geographic areas. Savings are to be calculated for all Medicaid beneficiaries in the geographic area regardless of eligibility category or managed care plan enrollment. At the time of the drafting of this report, the ACOs' shared savings plans have been filed with the state, and Rutgers Center for State Health Policy is working with Medicaid officials through the review process and providing technical guidance on the soundness of the shared savings methodologies.

The ACOs are incorporated as non-profit entities governed by representatives of area hospitals, primary care and behavioral health providers, and community members. They are required to contract with all hospitals, 75% of Medicaid primary care providers, and at least four behavioral

[8] The first performance period for savings measurement will be calendar year 2017.
[9] NJ Department of Human Services, Division of Medical Assistance & Health Services. "Accountable Care Organization." Accessed August 10, 2016. http://www.state.nj.us/humanservices/dmahs/info/aco.html.

health providers in their regions. The ACOs are not required to bear financial risk beyond initial investments and operating costs. One controversial aspect of the demonstration design that is discussed further below is that the participation of managed care organizations (MCOs), which cover over 95% of Medicaid enrollees, is voluntary. To date, two MCOs have partnered with ACOs.

Using Data to Advance the Goals of the ACOs

As part of the state's value-based health care and payment strategy, SIM resources were used successfully to support critical ACO activities including: (1) developing and initiating in January 2016 monthly HIPAA-compliant data feeds that include medical, dental, pharmacy, behavioral health, and eligibility claims data to enable the ACOs to identify patterns of avoidable cost and use and effectively deploy resources; (2) refining the savings and quality measurement strategies using comprehensive Medicaid claims and managed care encounter data; (3) enhancing an existing Learning Collaborative, directed by the NJ Health Care Quality Institute (NJHCQI), a sub-contractor on the SIM project team, to enable the ACOs to share experiences and consult with technical experts as they refined their strategies; and (4) drawing on available public documents and interviews with ACO leadership to identify needs for implementation assistance and contribute to development of the evaluation and monitoring strategy.

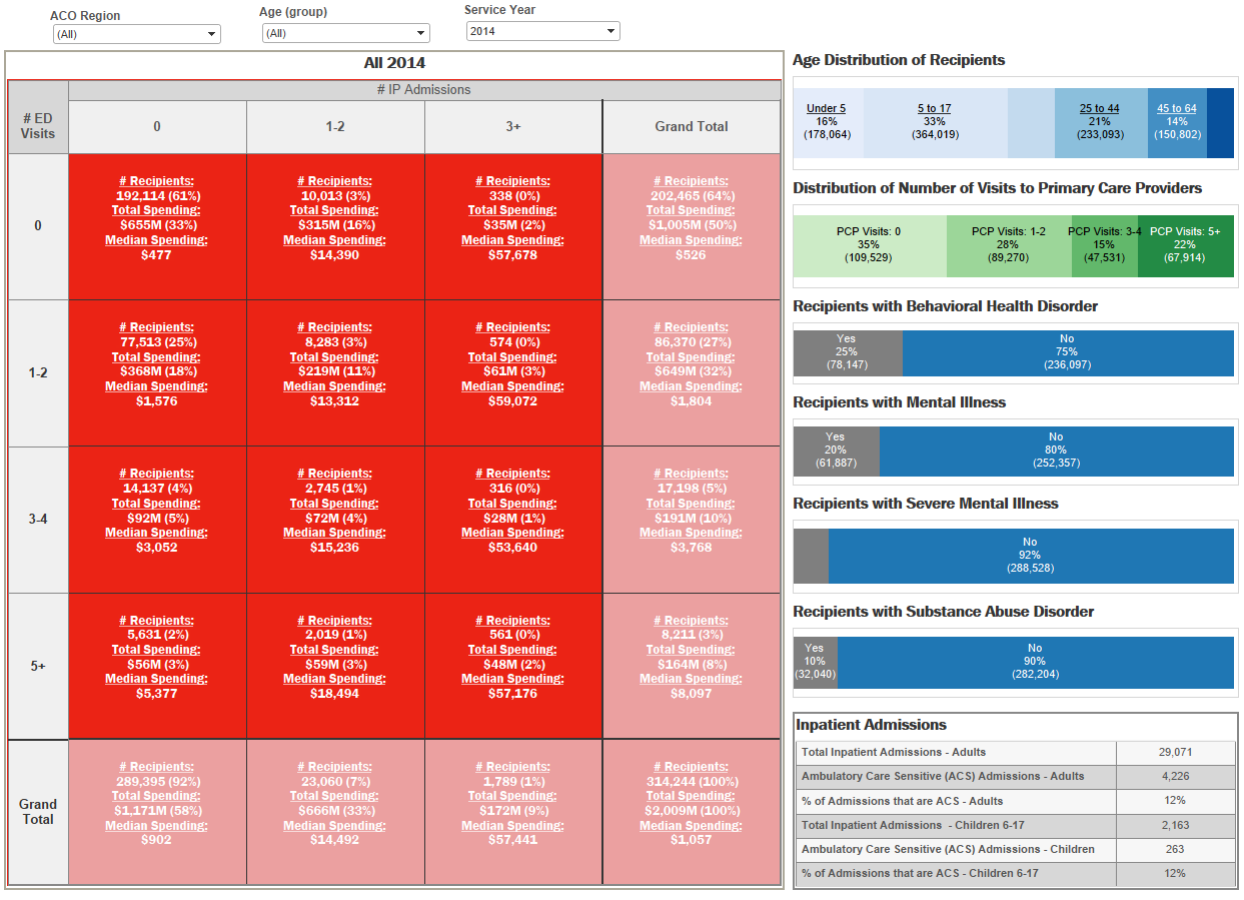
As the ACOs developed their infrastructure over the past year, one of the challenges that they immediately confronted was building the capacity to process and analyze Medicaid claims and encounter data. In order to meet the ACOs' needs in this regard, the team from the Center for State Health Policy engaged with a consultant to develop a data dashboard tool to enhance the ACOs' understanding of the Medicaid data for their attributed members. The use of Medicaid data for dashboard development was implemented along two parallel tracks. Track 1 involved the use of community-specific data with full patient identifiers to be used by healthcare providers in the development of patient care plans. Track 2 involves the use of statewide de-identified data currently overseen by CSHP to support ongoing community benchmarking with performance metrics that are applied consistently across the state.

In its role leading the ACO Learning Collaborative, the Quality Institute and the ACO communities worked directly with NJ Medicaid to establish appropriate agreements that would allow each community to view information about patients in their own ACO service areas. Rutgers CSHP has played an important advisory role in this phase of the dashboard activities but with no access to the identified patient data.

The second track of activities included the development of a single data dashboard using Tableau software. This dashboard model, shown with hypothetical data in Figure 3, has been

designed so that each ACO is able to view summary information about their own community as well as statewide Medicaid aggregates for comparison purposes. Designated officials from Medicaid have been given access to summary information about all three ACO communities. End users of this dashboard tool see only aggregated data displays using various tools in Tableau (e.g., charts, tables, maps). The ACOs have expressed that these dashboards have been extremely effective tools in not only shedding light on the health status and needs for their populations but also to benchmark their performance relative to other ACOs and the state as a whole. Rutgers CSHP's role is also to ensure that all performance measures in Tableau (e.g., spending, quality, utilization) are valid and consistent across all communities. As part of its sustainability strategy and commitment to informing and supporting the progress of the Medicaid ACOs, CSHP will continue to facilitate data sharing activities with the ACOs using these dashboards.

Figure 3: Model Dashboard



Note: This figure does not contain actual data. It is for illustrative purposes only.

Lessons Learned from the ACO Demonstration

With nearly a year of implementation of ACO activities completed, the SIM project team conducted a series of confidential key informant interviews with ACO leadership and other stakeholders involved in the development of the ACOs. The goal of these interviews was not to support finger pointing or criticism of the regulatory and certification process, but rather to assess the progress made to date and have these pilots inform the development of future value-based payment initiatives in the state. Findings summarized in "*New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process*"[10] point to five major challenges that were consistently identified by ACOs leaders and expert stakeholders who participated in these interviews.

First, as noted above, the ACO legislation requires that ACOs have adequate provider participation including 75% of the "qualified" primary care providers (e.g., physicians engaged in family or internal medicine, physician assistants, advanced practice nurses) in the designated zip codes. It further requires that these providers spend a minimum of 25% time treating Medicaid patients to be considered part of the ACO network. The challenge, referred to in conversations and in the report as the "denominator problem", resided in the fact that the 75% calculation depended on having access to a comprehensive list of providers in the catchment area. In order to advance the certification process, Medicaid officials used claims and encounter data to determine if the ACOs had met the 75% threshold for provider participation. While mindful of addressing the information needs of the applicant ACOs, Medicaid declined to make public these lists due to the proprietary nature of managed care organization network information. This became a critical decision because the inability to meet the provider participation requirement was the primary reason four ACO applicants were denied certification.

While building an adequate network of providers presented a critical challenge, a second obstacle that was identified through the interviews and echoed in other conversations with stakeholders during the SIM project, involved the statute making participation of Medicaid managed care organizations (MCOs) optional. This component of the legislation is particularly significant since over 95% of the state's 1.7 million NJ Medicaid beneficiaries receive care through a Medicaid MCO. While not requiring the participation of health plans, ACOs have had varying degrees of success in their value-based negotiations with the MCOs. Progress has been slow, but significant efforts continue on the part of all involved in the discussions.

[10] Thompson FJ, and JC Cantor. *The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process*. New Brunswick, NJ: Rutgers Center for State Health Policy, 2016. http://cshp.rutgers.edu/Downloads/10950.pdf.

A third challenge that was identified in the report has been somewhat mitigated with an addition to the recently passed budget. The legislation authorizing the ACO demonstration did not include state appropriations to support the start-up activities. The absence of initial state funding had implications for not only the ACOs but also proved challenging for the Medicaid agency that was constrained by staff resources to support the initiative. Understanding the importance of providing seed money to galvanize operations in the three certified ACOs, Governor Christie's FY 2017 budget included a $3 million appropriation with each ACO demonstration receiving $1 million in early July 2016 to fund their work. This investment is important for several reasons. First, it signals the state's commitment to the success of the Medicaid ACO demonstration and, second, it provides leverage for the ACOs to approach foundations and other funders to secure additional resources to sustain their interventions.

The authors also identified a fourth major challenge which involved the delay in promulgating regulations. The final regulations were adopted in 2014, nearly two-and-a-half years after the passage of the law, and the certification process extended another year to July 2015. Despite best efforts by the Medicaid agency and scores of stakeholder groups, the regulatory process was slowed by several significant and unexpected obstacles. The first barrier that needed to be confronted involved antitrust issues associated with the ACOs. The findings document the conversations that the Medicaid leadership initiated not only with the Centers for Medicare and Medicaid Services (CMS), but also the Federal Trade Commission (FTC) and the US Department of Justice (DOJ) before finally prevailing with the implementation of the demonstration.

The second delay that was experienced in this process was the length and complexity of New Jersey's rulemaking process. One important feature of any rulemaking exercise in New Jersey is the public comment period. While this is a significant and valuable opportunity for stakeholder engagement, the process of collecting and organizing public feedback to inform final regulations can be tedious and time consuming, particularly given the proscriptive nature of the original legislation.

The fifth and final lesson that was gleaned from the implementation experience revolved around issues of quality metric alignment and reporting. The NJ Medicaid ACOs are required to report on a series of voluntary and mandatory measures that examine performance on a host of indicators including emergency room use, health screening, and hospitalization rates for enrollees with chronic conditions, and hospital readmissions. In some cases, these ACO measures are not aligned with quality measures used by Medicaid ACOs and lack harmony with the quality data reporting for other programs around the state as well. Viewing this as a window to address this barrier, SIM resources were used to explore opportunities to further

metric alignment strategies to improve the efficiency and usefulness of data reporting. Analysis by the NJ Health Care Institute, which continues to work closely with the certified ACOs through the Learning Network, produced a core set of harmonized metrics that can be considered for adoption for future private and public quality initiatives (see Section 4 above).

After the conclusion of the SIM project, the Interdepartmental Working Group on Health Care[11] continued exploring ways to advance project goals. This included surveying the degree of alignment between the "Harmonized Core Metrics" and those used by the Division of Medical Assistance and Health Services (Medicaid). It found:

- *The 2016 NJ Health Care Quality Institute - Quality Measure Alignment Report does not include metrics specific to the Managed Long-Term Services and Supports (MLTSS) or Developmental Disabilities (DD) populations; although, they did incorporate metrics taken from the Medicaid MCO contract and many of the Quality Strategy Objectives taken from Healthy NJ 2020 Topics.*
- Of the 31 Harmonized Metrics, Core-Medicaid receives HEDIS data from the MCOs on 19 of them.
- Of the 12 Harmonized Metrics that Core-Medicaid does not receive, some measures may be more challenging than others to obtain data from the MCOs. Some of these 12 measures are presently written for the Medicare population or involve FFS carve-out benefits.
- Medicaid annually reports to CMS on Adult Core Set Measures through MACPro. There are 30 Adult Core Set Measures for 2017; DMAHS intends to report on 12 of them. Eight of the 12 are Harmonized Metrics.
- Medicaid annually reports to CMS on Child Core Set Measures through MACPro. There are 27 Child Core Set Measures for 2017; DMAHS intends to report on 17 of them. Eleven of the 17 are Harmonized Metrics.
- DMAHS, through our annual MACPro reporting, would continue to report on the additional Core Set Measures that are not Harmonized Measures.
- The Office of Quality Assurance (OQA) has continually evaluated the feasibility of metrics and has included new measures in the MCO contract over the past years. We would evaluate the feasibility of Harmonized Metrics and, likewise, include them in the MCO contract if found appropriate.

[11] The Interdepartmental Working Group on Health Care is chaired by the Governor's Policy Advisor for Health Care and includes representatives from the Department of Banking & Insurance, the Individual and Small Employer Health Coverage programs, the Division of Medical Assistance and Health Services (Medicaid) in the Department of Human Services and the Department of Health, including the Division of Mental Health and Addiction Services.

Sustaining Progress

The analytic work undertaken to support the Medicaid ACO demonstration project will continue beyond the resources provided under the NJ SIM Design award. As previously noted in this report, Governor Christie allocated $3 million in the State Fiscal Year 2017 budget to support the work of the three certified Medicaid ACOs. This funding was awarded at the mid-point of the first performance year and demonstrated the administration's commitment to supporting these initiatives. In addition, the Center for State Health Policy has received funding from the Agency for Healthcare Research & Quality (AHRQ) and The Nicholson Foundation to advance the evaluation of the Medicaid ACOs and dissemination of key findings, respectively. These are important activities to sustain and have the potential to significantly inform the post-demonstration Medicaid policymaking strategy.

Strategies to Achieve Integration of Physical and Behavioral Health Care

Coordinating and integrating behavioral and physical health is one of the core components of New Jersey's value-based health care delivery transformation strategy and one of the three primary goals of the NJ SIM design model. The state has successfully leveraged opportunities for enhanced federal matching funds for Medicaid enrollees with chronic conditions who participate in health home programs. As part of its 2012 Medicaid Comprehensive Waiver, New Jersey launched the Medicaid BHH initiative in Bergen and Mercer counties. The model began with three integrated care sites in Mercer County and one site in Bergen County. The New Jersey BHH model provides high intensity, coordinated services targeted to individuals with the highest level of behavioral health needs, the vast majority of whom also have co-occurring substance use disorders. New Jersey's investment in, and financial commitment to the expansion of these efforts, beyond the SIM project, will be further detailed below.

About Medicaid Health Homes

A provision within the Affordable Care Act governing Medicaid titled "State Option to Provide Health Homes for Enrollees with Chronic Conditions"[12] allows states to create programs with comprehensive care coordination for Medicaid beneficiaries with complex chronic conditions. Upon approval by the federal government of a state plan amendment (SPA), such programs may receive enhanced 90% federal matching funding for the first two years of health home program operations.

According to the Centers for Medicare & Medicaid Services (CMS), the goal of the health home option is "…to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health

[12] § 2703, Patient Protection and Affordable Care Act, 2010.

care, in keeping with the needs of persons with multiple chronic illnesses. The whole-person philosophy….is fundamental to a health home model of service delivery. CMS expects health homes to build on the expertise and experience of medical home models, when appropriate, to deliver health home services."[13]

Six services are at the core of the Medicaid health home model:

- comprehensive care management
- care coordination and health promotion
- comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- patient and family support (including authorized representatives)
- referral to community and social support services, if relevant
- use of health information technology to link services, as feasible and appropriate

Characteristics of Medicaid Behavioral Health Homes

States may pursue health homes that focus on individuals with severe behavioral health conditions. A 2012 report from the federal Center for Integrated Health Solutions[14] defines four key features of effective care in BHHs. The care must be: 1) person-centered; 2) population-based; 3) data driven; and 4) evidence-based. The report proposes that the behavioral health home should be organized under the Chronic Care Model, with self-management support for consumers, a delivery system where multidisciplinary teams provide comprehensive care management and decision support to patients, clinical information systems available to team members, and community linkages to augment behavioral health home services. There are several potential frameworks for behavioral health homes including: 1) the in-house model, where the behavioral health organization controls both behavioral and primary care services; 2) the co-located partnership model, where the behavioral health organization partners with providers who provide on-site primary care, 3) and the facilitated referral model, where the behavioral health organization coordinates primary care services provided off-site.

Learning from Other States: Evidence of Potential Impact

The piloting of Medicaid medical homes nationally is a recent development and direct evidence on their effectiveness has only begun to emerge. However, there is strong evidence that patient-centered medical homes, on which behavioral health homes are modeled, have the

[13] Centers for Medicare & Medicaid Services. *Health Homes for Enrollees with Chronic Conditions*. SMDL#10-024, ACA #12. Baltimore: Centers for Medicare & Medicaid Services, 2010. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

[14] Alexander L, and B Druss. *Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features*. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions, 2012. http://www.integration.samhsa.gov/clinicalpractice/cihs_health_homes_core_clinical_features.pdf.

opportunity to reduce patient utilization and costs and improve care. The Patient-Centered Primary Care Collective reviews evidence annually that is published in peer-reviewed journals and state and industry reports. From 2013 to 2014, 71% of studies found evidence of cost reduction in medical homes, and 89% found evidence of improvements in utilization; the majority of studies also found improvements in quality, population health and preventive services, and access to care.[15] Medical homes in place for longer periods of time have shown more favorable outcomes, and researchers estimate that the time necessary for effective transformation can be a minimum of two to four years.

There is also a wealth of evidence regarding intensive, collaborative services provided to people with serious mental illness (SMI). More than 70 randomized controlled trials of collaborative care over a 15-year period have shown the effectiveness of this model among patients with serious mental illness in improving outcomes, reducing cost, and addressing health disparities.[16] Early experiences from states that have implemented Medicaid BHH models offer the most direct evidence to date that New Jersey is on the right track and its approach can yield substantial benefits and holds the prospect of achieving value-based care. The Interim Report to Congress on the Medicaid Health Home State Plan Option (2014) summarized promising results from early adopters of Medicaid BHH models.[17]

For example, Missouri was out of the gate early with regard to the implementation of both primary care health homes and community mental health center (CMHC) health homes. In 2010, Missouri began an outreach program to high-cost Medicaid enrollees who had a psychiatric diagnosis but were not connected with a community mental health center. This project demonstrated immediate and significant improvements in the health of enrollees and significant reductions in the cost to Medicaid for their care. This program influenced the design of CMHC Healthcare Homes, which began serving enrollees in January of 2012. An analysis of service utilization in the year prior to enrollment compared with the year after enrollment in

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[15] Nielsen M, A Gibson, L Buelt, P Grundy, and K Grumbach. *The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2013–2014*. New York: Patient-Centered Primary Care Collaborative, Milbank Memorial Fund, 2015. http://www.milbank.org/uploads/documents/reports/PCPCC_2015_Evidence_Report.pdf.

[16] Unützer J, H Harbin, M Schoenbaum, and B Druss. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. Baltimore: Health Home Information Resource Center, 2013. http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf.

[17] Ormond B, E Richardson, B Spillman, and J Feder. *Health Homes in Medicaid: The Promise and the Challenge*. Washington, DC: Urban Institute, 2014. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413032-Health-Homes-in-Medicaid-The-Promise-and-the-Challenge.PDF.; and Moses K, and B Ensslin. *Seizing the Opportunity: Early Medicaid Health Home Lessons*. Hamilton, NJ: Center for Health Care Strategies, 2014. http://www.integration.samhsa.gov/integrated-care-models/Seizing_the_Opportunity-_Early_Medicaid_Health_Home_Lessons_-1-.pdf.

the health home showed a 12.8% decline in hospitalization and an 8.2% decline in emergency room use.[18] Results from 2015 show increasing improvements in health outcomes as the program has progressed.[19]

New York also documented approximately a 30% decrease in inpatient utilization among a subset of continuously enrolled individuals, and most states expected the cost savings from improved health and reductions in utilization to cover the costs of health home programs after the enhanced match ended.[20]

New Jersey's Behavioral Health Home Initiative

As noted above, in 2014 New Jersey implemented the Medicaid Behavioral Health Home initiative project in Bergen and Mercer counties. The effort was authorized under New Jersey's 1115 Comprehensive Medicaid Waiver for two programs, one serving adults and one specific to children. The adult program initially included four sites (three in Mercer and one in Bergen counties). The Division of Mental Health and Addiction Services (DMHAS) has a certification process for provider organizations to become BHHs. These providers may go through a provisional certification for up to two years, at which time they must be accredited, certified, or recognized by a DMHAS-approved national accrediting body.[21]

The children's BHH initiative serves children with serious emotional disturbance and at least one chronic medical condition and adults with serious mental illness who are at risk of high service utilization due to chronic illness or disability. Both the Children and Adult Initiatives aim to improve care and reduce cost by providing high quality, continuous behavioral health services and reducing avoidable acute hospital care. Each adult health home is expected to serve approximately 250 consumers. The NJ SIM design award provided needed resources to support data analysis to inform the understanding of cost and quality outcomes for these initiatives and inform the development of expansion strategies.

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[18] Missouri Department of Mental Health, and MO HealthNet. *Progress Report: Missouri CMHC Healthcare Homes*. Jefferson City: Missouri Department of Mental Health, 2013. http://dmh.mo.gov/docs/mentalillness/prnov13.pdf.

[19] McGinty B, and R Glavin. "Missouri's Journey to Healthcare Home." Presentation given to the Community Behavioral Health Care Spring Forum in Springfield, IL, April 14, 2015. http://www.cbha.net/Resources/Conference/Missouri's%20Journey%20to%20Healthcare%20Home.pdf.

[20] U.S. Department of Health and Human Services, Office of the Secretary. *Interim Report to Congress on the Medicaid Health Home State Plan Option*. Washington, DC: U.S. Department of Health and Human Services, Office of the Secretary. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/downloads/medicaid-health-home-state-plan-option.pdf.

[21] NJ Department of Human Services, Division of Mental Health & Addiction Services. *Certification Process*. Trenton: NJ Department of Human Services, Division of Mental Health & Addiction Services. http://www.nj.gov/humanservices/dmhas/initiatives/integration/Certification_Process.pdf.

In addition, New Jersey has implemented a BHH Learning Community (LC) to support capacity building among potential providers. DMHAS has been able to provide state-only start-up funds for adult providers for the first two Learning Communities. Funding for future LCs will be contingent upon resources. BHH providers are required to have electronic health records and to be participating or working on participating in any existing health information exchanges. These efforts are also aligned and coordinated with the goals of the state's HIT plan overseen by the NJ Department of Health. BHH providers are also required to have an affiliation agreement with regional hospitals to ensure a formalized relationship for transitional care planning which must include communication of inpatient admissions and identification of individuals seeking emergency department services.

The BHH initiatives currently underway address the needs of both adults and children, though not jointly.[22] Adults 18 and over served by the BHH must fall within a set of diagnosis codes to be eligible (schizophrenic disorders, bipolar disorder, psychoses, borderline personality, or hallucinations).[23] Contracts with managed care organizations require coordination and non-duplication of BHH services, and full or partial co-location of primary care must be established within three years of initial certification.

In order to address the needs of the "whole person," the BHH care teams are integrated and multi-disciplinary and, depending on the specific needs of the adult, include a nurse care manager (minimum credential RN), a care coordinator (LSW or LPN), a health and wellness educator, and consultative services of a psychiatrist and a primary care physician. These initiatives also have the option of enhancing the program design model to include a nutritionist/dietician, peer, pharmacist, or hospital liaison. There are three rate tiers of per member per month reimbursement: engagement (multiple contacts per week, generally applies for the first three months of enrollment to assess the client and develop a care plan),[24] active (multiple contacts per month, generally the next 24 months for the BHH to perform its key functions)[25] and maintenance (minimum of one contact per month, based on clinical need).

The children (up to age 21) who are enrolled in the BHHs have been diagnosed with serious emotional disturbance and co-occurring conditions requiring coordination. Their needs are

[22] Details can be found in New Jersey's approved State Plan Amendment for adults at http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/nj/nj-14-0005.pdf. (accessed August 10, 2016). Clients who participated in the earlier SAMHSA-funded integration programs will be excluded from calculations of cost savings.

[23] For specific codes, see http://www.nj.gov/humanservices/dmhas/initiatives/integration/Diagnosis_Code.pdf. (accessed August 10, 2016)

[24] A new phase of engagement can begin for those who have previously completed an engagement stage but has not engaged in the active or maintenance phases, if they use a crisis or hospital service.

[25] This phase can be extended or reduced based on clinical needs of the client.

served by enhancing the care teams with care management organizations with experience serving children and families with the most complex needs.[26]

Sustaining Progress

With ten Behavioral Health Homes (BHH) currently in place, and a new BHH Learning Community to support prospective BHHs which started in early 2017, the State's strong commitment to behavioral health integration and programs that support addiction recovery is evident.

Speaking at a BHH in Mercer County in April 2016 about the state's BHH expansion strategy and announcing the plan to increase provider payment rates, Governor Christie noted:

> "….I am more convinced than ever that our multi-program, multi-service approach to treating addiction disorders is fundamentally changing the landscape of how we get people treatment for the better. We are reaching people who need help in every way we can ---in hospitals, through the court system, in prisons, through a hotline referral model and through mental health services. There's no singular solution because there's no singular type of person affected. We have pulled out all of the stops and the outcomes are clear: our programs are helping people seek and sustain recovery from addiction."[27]

Section 6: Delivery System Transformation

In recent years, New Jersey's public and private sectors have built significant momentum toward a healthcare delivery system based on advanced primary care practice and value-based financing. In spite of significant public and private transformation efforts, achieving a fully transformed delivery system in New Jersey (e.g., achieving the CMS goal of having 80% of payments from all payers linked to value and full accountability for quality and patient engagement) remains a challenge.

In an effort to inform the understanding of the primary care landscape in New Jersey and provide context to New Jersey's Delivery System Transformation strategy, under the NJ SIM project the 2015 NJ Primary Care Practice Survey was designed and fielded among a statewide probability sample of 698 primary care providers (36.4% response rate). The goals of the Survey were threefold and aligned with the SIM priorities:

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[26] Details can be found in New Jersey's approved State Plan Amendment for children at http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/downloads/nj/nj-14-0006.pdf. (accessed August 10, 2016)

[27] State of New Jersey Office of the Governor. "Governor Christie Announces Expansion of Behavioral Health Homes." Last modified April 7, 2016. http://nj.gov/governor/news/news/552016/approved/20160407c.html.

- Identify the extent to which NJ primary care physicians are engaged in value-based payment and delivery alternatives to fee-for-service and their capacity to deepen that engagement in the future
- Identify the degree of integration of behavioral health care with primary care services and the potential to improve integration in the future
- Measure the perceived availability of referral to smoking cessation services and explore the emerging role of e-cigarettes/vaping

We know from the Survey that nearly two-thirds of NJ primary care physicians are either in a solo practice (31%) or in a group of 3 or less (33%) and more than three-quarters work in single-specialty practices. The vast majority (70%) of practices are physician-owned (as opposed to hospital or system based), and the cohort is aging (39.5% are 55 years or older). It is important to understand the characteristics and nuances of the primary care environment in New Jersey because these realities will influence how quickly, and through what mechanism, transformation objectives can be achieved and sustained.

Convening a Delivery System Transformation Workgroup

The Delivery System Transformation strategy under the NJ SIM was two-pronged. First, in the initial months of the award, the project team created the NJ Delivery System Transformation Workgroup (DSTW or "Workgroup") that was tasked with three objectives that included: (1) comprehensively assessing the current state of the NJ delivery system; (2) working to coordinate, align, and leverage existing public and private transformation initiatives; and (3) identifying opportunities to accelerate system transformation through collaboration or policy adoption. This Workgroup was chaired by Terry Shlimbaum, MD, a practicing family physician, researcher, and teacher and a past president of the NJ Academy of Family Physicians, and included representatives from the Governor's Office, Seton Hall University's Center for Health & Pharmaceutical Law & Policy as well as leadership from the Rutgers CSHP and Robert Wood Johnson Medical School Department of Family Medicine & Community Health. The DSTW was responsible for developing and recommending to the Steering Committee the priority topics for the agenda for the two statewide transformation summits which took place in June and November 2015. The DSTW was also actively involved in the design of the Primary Care Practice Survey.

The second strategy under the Transformation plan called for the building of a virtual Delivery System Transformation Resource Center that was led by colleagues at the Robert Wood Johnson Medical School Department of Family Medicine and Community Health who, with over a decade of experience in transformation research and practice design, were well-suited to advance this important series of activities. This collection of work included a comprehensive

literature search and an assessment of advanced primary care models around the nation that might hold promise for adaptation in New Jersey. In addition, the project team reached out to providers and other health care experts around New Jersey to document current efforts within the state to facilitate delivery system capacity building and transformation while also identifying barriers that impede success. Specifically, this design work focused on three priorities: (1) improving primary care to facilitate engagement in patient-centered medical home and other advanced primary care practice approaches; (2) improving population health and patient-centered care through use of health information technology; and (3) achieving effective engagement and integration of behavioral health services with primary care (also a core aim in the overall NJ SIM).

While there are many initiatives already underway in New Jersey, much work is still needed to replicate best practices and achieve meaningful and sustained primary care transformation throughout the state. Lessons learned from patient-centered care programs around the nation that have achieved higher quality and cost savings can be adapted to New Jersey.

Facilitating Advanced Primary Care in New Jersey

In a report on Primary Care Transformation[28] prepared by colleagues at RWJMS Department of Family Medicine and Community Health, the critical principles of Patient-centered Medical Home (PCMH) modeling that are vital to successful system redesign were examined.

Selected system or policy requirements that are key to developing patient-centered care models were identified in the report and include:

- Multi-payer participation in alternative payment models to align resources with consistent incentives
- Payment reforms that include up-front and immediate financial gain
- A neutral convener to bring stakeholders together
- Consistent standards for PCMH recognition and certification
- Ongoing support and technical assistance to practice sites
- Reliable and timely data, alignment of measurements, and automated reporting of measures to payers
- Support for evaluations to demonstrate effectiveness of programs
- Collaborative learning to share information and experiences, either in-person or virtually

[28] Ferrante JM. *Facilitating Engagement in Primary Care Transformation in New Jersey*. New Brunswick, NJ: Rutgers Robert Wood John Medical School, Division of Family Medicine & Community Health, 2016.

- Sufficient commitment of time (minimum 3-5 years) to see significant improvements in quality and cost

In addition to these external influences, there are factors that are internal to the practice that are key to any redesign effort. Changes needed at the practice level include:

- Workflow or process restructuring to move from physician-centered to patient-centered care
- Integrated care teams whereby clinicians and staff work at the "top of their license"
- Risk stratification to monitor and target high-intensive services for patients with complex conditions at risk for poor health, emergency room visits, and hospitalizations
- Improvement of population health by proactively tracking patients for adherence to clinical guidelines, medications, and specialist appointments
- Conservation of resources by following evidence-based guidelines, avoiding low value tests, procedures, and treatments, and using preferred local specialists who share the philosophy of conscientious conservation
- Restructuring of physician income that is based not just on productivity but also on quality of care, patient experience, resource utilization, and contribution to practice-wide improvement activities
- Committed leadership that invests in people and fosters motivation, a culture of improvement, and an adaptive learning environment
- Adding new positions or expanding roles of other health professionals:
    - Nurse practitioners and physician assistants, behavioral health providers, nutritionists, pharmacists, health educators, social workers, case managers, care coordinators, patient navigators, community lay health workers
    - Information technology and quality improvement experts
    - Addressing educational and regulatory issues to safely, uniformly, and effectively expand roles of medical assistants

The Role of Health Information Exchange in Practice Transformation

The RWJMS project team reached out to leadership of eight New Jersey Medicare Shared Savings Plans (MSSPs) to learn more about the ways in which they assist their member practices in practice transformation, specifically with regard to advancing the electronic exchange of health information. The findings from those interviews point to three primary areas that can pose barriers to implementing health information exchange. They include data issues, cost, and system or provider challenges.

With regard to the data, practices are stymied by the lack of standardization, having to integrate multiple electronic health records (EHRs) into one electronic network. ACO leaders

described contending with anywhere from 17 to 40 different EHR systems to aggregate data and run reports.

Financial costs also proved to be a major and persistent barrier to successful exchange of information. One ACO leader who was interviewed reflected on an EHR vendor charging $25,000 per practice to connect six practices to the network. Given realities of modest budgets for small practices, such a price tag made connectivity infeasible.

Finally, MSSP leaders describe challenges with provider burnout and being overwhelmed by the volume of data and reports that they are expected to manage. There was some sense that the collection of these reports left gaps in terms of "actionable" information that could impact change.

Those MSSPs that have experienced success with their health information exchange are the ones that have established bidirectional exchange of information, i.e., information moving from the practices' EHRs to shared networks and from the networks to the EHR. This led to improvements in care management of high-risk patients and increased physician engagement in data sharing and practice transformation. Such connectivity is usually facilitated when one EHR system is implemented system-wide, though costs can again prove to be an impediment to system/practice-wide adoption. Several ACO leaders expressed desire for a single overarching HIE system in New Jersey to improve population health for all residents of New Jersey. The key difference between the MSSPs that achieved shared savings in their first year of operation and those that did not was a commitment by ACO leadership and participating providers to the ideals of HIE and practice transformation.

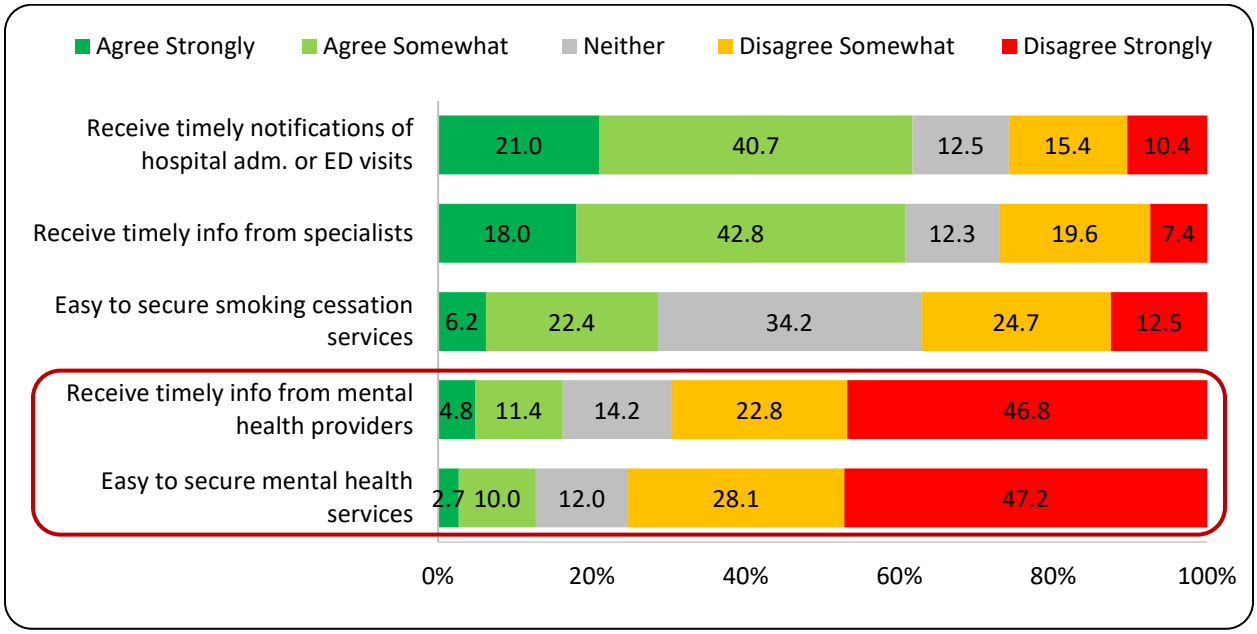
The Challenge of Integrating Behavioral Health Care and Primary Care

Increasing access to comprehensive and well-coordinated behavioral health services has been a priority of New Jersey Governor Chris Christie's administration, and that goal has been advanced under the NJ SIM. In recent years, there has been significant interest on the part of New Jersey policymakers and stakeholders to learn more about the facilitators and barriers to successful behavioral health integration in the state. The SIM project found there is broad consensus among policymakers and stakeholder groups that pursuing physical and behavioral health care on parallel tracks for patients with mental health diagnoses does not serve that patient population well. With models of integration existing in approximately thirty states, colleagues from RWJMS Department of Family Medicine and Community Health explored some of the common elements of successful models that can serve to inform future policymaking in New Jersey.

In their review of the current national landscape, Clemow and Panza[29] observed that many of the models that have been implemented in other states have had some alteration of the provider reimbursement model for behavioral health services to incentivize coordinated care. In addition, many states have relied on grant support (including in some cases like New Jersey, SIM funding) to galvanize efforts that were in early stages of development or implementation. Many of these programs included services specifically targeted at children and adolescents, acknowledging the special needs of those age groups. Most state programs are built around at least some co-located services in primary care, with evidence showing that the best and most consistent outcomes appear to come from highly integrated and co-located services.

Findings from the NJ Primary Care Practice Survey provided evidence that showed a high level of dissatisfaction among PCPs with regard to the accessibility of behavioral health services for their patients and communication with behavioral health providers (see Figure 4 below).

Figure 4: NJ PCP Views on Selected Aspects of Their Practice Environment



Source: 2015 NJ Primary Care Practice Survey.

As problematic, 76% of respondents reported no BH resources of any kind within their practices and nearly 72% reported no plans to add them at this time (data not shown).

These survey results, coupled with other data, directly informed two major policy initiatives that were announced following the conclusion of the SIM Design project:

[29] Clemow L, and E Panza. *Achieving Effective Engagement and Integration with Behavioral Health Services*. New Brunswick, NJ: Rutgers Robert Wood John Medical School, Division of Family Medicine & Community Health, 2016.

1. The statewide expansion of the Pediatric Behavioral Health Collaborative, with an additional $5 million in state funding announced by Gov. Christie in January 2017. This successful pilot program uses telehealth hubs to connect pediatricians needing a behavioral health consultation with a psychiatrist on call. Participating pediatricians also receive training on how to screen children for substance use and behavioral health conditions and provide an immediate connection to a specialist and referral source. In urgent cases, a face-to-face consultation can be arranged the same day.
2. The transfer of mental health and addiction functions from the Department of Human Services to the Department of Health, pursuant to Reorganization Plan 001-2017 on June 29, 2017. The Plan's Rationale section stated in part:

> "A random survey of primary care providers in New Jersey conducted by the Rutgers Center for State Health Policy asked whether they agreed or disagreed with the proposition that it is easy to secure mental health services for their patients. Of the respondents, 47.2% disagreed strongly and another 28.1% disagreed somewhat."

Opportunities to Address Barriers to Integrated and Coordinated Care in New Jersey

Currently, there exist state-level regulatory and licensing barriers as well as provider reimbursement issues that need to be resolved before system-wide behavioral health integration can be achieved in a comprehensive way. An area of considerable focus for policymakers has been harmonizing the licensing requirements between the NJ Department of Health, which regulates federally qualified health centers (FQHCs) as ambulatory care facilities that provide primary care, and the Department of Human Services that oversees mental health programs and facilities in the state. Until very recently, existing policies prevented the provision of behavioral health services in the FQHC primary care setting, making the delivery of integrated care to low income, frequently complex patients infeasible. Significant progress was made with the issuance of a *"Shared Space Waiver"*[30] by the NJ Department of Health, relaxing restrictions on behavioral health treatment in an FQHC or ambulatory care setting.[31] On July 13, 2017, Governor Christie signed P.L. 2017, c.107, sponsored by Senator Joseph F. Vitale, which also permits the sharing of clinical space by licensed primary care facilities offering outpatient services for primary medical care, outpatient mental health care, and/or outpatient substance use disorder care.

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[30] *See "*Waiver to Permit Sharing of Clinical Space," dated October 19, 2015 and available online at: http://www.state.nj.us/health/healthfacilities/documents/ac/primary_care_facilities_permitting_sharing_of_clinical_space.pdf.

[31] Jacobi JV, TA Ragone, and K Greenwood. *Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in NJ*. Newark, NJ: Seton Hall University School of Law, Center for Health & Pharmaceutical Law & Policy, 2016.

Further progress was made with Reorganization Plan 001-2017, which transferred mental health and addiction functions to the Department of Health, thus laying the groundwork for the integration of physical and behavioral health care.

Pursuant to this Reorganization Plan, on Dec. 15, 2017, the Department of Health issued Guidance[32] "to facilitate the integration of outpatient care for physical, mental health, and substance use disorder facilities licensed by the Department." Among other things, this Guidance announced the Department's intention to:

- Create a single-license system allowing outpatient health care providers to "maintain a single license for primary care, mental health care and substance use services."
- Harmonize the licensing and inspection requirements for physical, mental and substance use disorder services.
- Issue further guidance on sharing of clinical space.
- Establish a "single point of entry" for health care providers wishing to offer integrated health care.
- Work with the Department of Human Services to explore integrated funding solutions.
- Consult with stakeholders throughout this process.

One of the other significant obstacles to integrated care is the inability of treatment providers to share patient health information in a timely way. Under the NJ SIM, colleagues from the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law (SHU) who participated in the Delivery System Transformation Workgroup completed a legal analysis to unpack this complex issue.[33] The goals of this research were to: (1) identify and analyze the relevant federal and New Jersey laws regarding the sharing of patient health information among treatment providers; (2) document the challenges to health information sharing among treatment providers that relate to these legal requirements; and (3) explore opportunities to facilitate more successful exchange of treatment information for integration. To inform their investigation, SHU conducted a series of interviews with providers, regulators, health information exchanges (HIEs), health information organizations (HIOs), consultants, privacy attorneys, advocates, and researchers to learn more about the specific problems confronting providers.

[32] New Jersey Department of Health. "Guidance 1-2017: Integrated Health–Outpatient Licensure and Inspection." Accessed December 12, 2017. http://nj.gov/health/healthfacilities/documents/CN/guidance/guidance_1_2017.pdf.

[33] Adams Ragone T. *Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers*. Newark, NJ: Seton Hall University School of Law, Center for Health & Pharmaceutical Law & Policy, 2016. http://cshp.rutgers.edu/Downloads/10980.pdf.

In her report entitled *Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers*, Tara Ragone found that one of the most significant barriers to information sharing is misinformation. A common theme in the interviews was that providers are fearful of violating federal or state privacy laws, so they are hesitant to share patient health information. This is particularly true when it comes to behavioral health records as the law treats these records differently in some situations, Ragone cited. Colleagues at SHU also received funding from The Nicholson Foundation to examine and develop a crosswalk of the state's Primary Care and Behavioral Health regulations.

The approaches of the federal government and the State of New Jersey to regulating confidentiality in this context are quite distinct. There principally are two sources of federal requirements – the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, which applies to a broad array of health records; and 42 C.F.R. Part 2, commonly known as "Part 2", which creates heightened confidentiality protections for substance use disorder treatment and prevention records. Changes to 42CFR Part 2, recently announced by SAMHSA, have the potential to improve information sharing between Substance Use Disorder Treatment providers and Primary care providers.[34]

In contrast, the report goes on to document the scores of New Jersey statutes and regulations that establish confidentiality requirements for a range of health care facilities, providers, and professionals, as well as for several categories of sensitive, disease- or condition-specific information.

It is evident that there is aligned support, both at the federal and state level, in favor of integrating behavioral and physical health. Stakeholder groups are uniting behind the rigorous behavioral health literature which demonstrates integration's positive effects on access and clinical outcomes. Uncoordinated care has meant that patient health information has been "siloed" and it remains unclear, in many cases, who has the legal authority to access these records to treat the full spectrum of the patient's medical needs.

Sustaining Progress

Efforts to advance delivery system transformation, particularly at the primary care level, and eliminate regulatory barriers to support behavioral and physical health integration continue to move forward in New Jersey.

[34] Substance Abuse and Mental Health Services Administration. "New Rule Improves the Exchange of Medical Information in Ways that Protect the Privacy of People Receiving Substance Use Treatment." Last modified January 13, 2017. https://www.samhsa.gov/newsroom/press-announcements/201701131200.

Behavioral health integration is a cornerstone of the NJ Medicaid 1115 Comprehensive Waiver, which has been extended through June 30, 2022. Using waiver authority, the State proposes to integrate behavioral and physical health by transitioning behavioral health into the managed care benefit plan. In addition, the waiver calls for the implementation of an incentive payment structure that rewards health care systems that achieve performance-based behavioral health integration goals.[35]

Finally, as noted above, the transfer of Mental Health and Addiction Functions to the Department of Health and its guidance on Integrated Health – Outpatient Licensure and Inspection are intended to facilitate the integration of physical and behavioral health care and to address the current epidemic of opioid addiction as the public health crisis that it is.[36]

Section 7: Population Health Improvement

About New Jersey's Population Health Improvement Plan

In 2013, New Jersey completed **Healthy New Jersey 2020** (HNJ2020), the state's health promotion and disease prevention agenda, led by the Department of Health (DOH). HNJ2020 (http://www.state.nj.us/health/chs/hnj2020/) is the result of a multiyear planning process that reflects input from a diverse group of individuals and stakeholder organizations and serves as the foundation for New Jersey's State Health Improvement Plan (SHIP). HNJ2020 provides a comprehensive view of the overall health status of New Jerseyans and serves as a framework for planning, goal setting, and measuring progress toward achieving agreed-upon health improvement goals across multiple sectors. Regional meetings, convened by Rutgers CSHP in 2012 on behalf of DOH, engaged over 100 representatives of local health departments, community- and faith-based organizations, educators, healthcare providers, state agencies, and private businesses. Discussions at these meetings and input collected in a survey of over 200 stakeholders informed the development of 112 health improvement goals in 20 priority areas with a focus on chronic conditions including asthma, diabetes, obesity, hypertension, and tobacco use. The strategies identified in Healthy New Jersey 2020 served as the starting points

[35] NJ Department of Human Services, Division of Medical Assistance & Health Services. *Strengthening Medicaid: Alignment & Redesign through Care Integration*. NJ FamilyCare 1115 Comprehensive Waiver Demonstration application for renewal. Trenton: NJ Department of Human Services, Division of Medical Assistance & Health Services, 2016. http://www.state.nj.us/humanservices/dmahs/home/NJ_Comprehensive_Waiver_Renewal_for_public_comment.pdf.

[36] On Jan 17, 2017, Governor Christie signed Executive Order No. 219, which declared, in part: "The abuse of and addiction to opioid drugs is a public health crisis in New Jersey, necessitating the marshalling of all appropriate resources to combat its harmful effects on the citizens of our State." Available online at http://nj.gov/infobank/circular/eocc219.pdf.

for all the population health improvement plan (PHIP) activities completed under the NJ SIM Design Model, with specific emphasis on reducing pre- and post-natal tobacco use in women enrolled in Medicaid.

Occurring midway through the state's Population Health Improvement Plan, resources from the NJ SIM advanced HNJ2020 priorities in two significant ways. First, through robust and broad stakeholder engagement at six regional forums, the project team was able to collect input and assess progress toward specific population health improvement goals and milestones. These conversations provided a well-tuned pipeline of feedback from the community and other experts and identified best practices and areas of implementation success, as well as opportunities for mid-course correction. The second way in which the NJ SIM advanced the goals of HNJ2020 is through rigorous research and analysis of Medicaid, birth record, and other data that will inform strategies to improve birth outcomes and related efforts to increase participation in maternal smoking cessation programs.

Stakeholder Engagement

Throughout October and November 2015, the NJ DOH hosted a series of six forums on topics aligned with the Healthy New Jersey 2020 priorities, or leading health indicators (LHIs) including: 1) improving birth outcomes and childhood immunization rates, 2) reducing the burden of chronic conditions such as heart disease and obesity, and 3) improving access to primary care. Overall, there were 170 participants in these meetings, representing 67 organizations and departments. The purpose of these regional meetings was to begin a mid-course assessment of HNJ2020, and New Jersey's State Health Improvement Plan (SHIP) overall. NJ DOH grantees, local public health agencies, and community stakeholders were convened to assess the impact, value, and success of health improvement activities taking place statewide, and identify opportunities for acceleration or redirection of resources. These meetings were hosted across the state in six, predominantly high-need areas: Asbury Park, Camden, Newark, Paterson, Trenton, and Vineland.

Updates on how these priority areas are being addressed were illustrated through stories from the field offered by community agencies and partnering organizations. An interactive feedback session followed each community presentation in order to explore emerging health indicators and discuss recommendations for advancement over the next five years.[37]

[37] NJ Department of Health. "Healthy NJ 2020 Regional Meetings Convened 170 Stakeholders from 6 Cities." *NJ Health Matters,* January–February (2016): 3. http://www.nj.gov/health/newsletter/documents/mar_2016_newsletter.pdf.

What We Learned and Next Steps

At the conclusion of each meeting, participants were asked to complete a questionnaire to enhance the feedback collected during the conversation. Some specific themes that emerged from these evaluations included:

- Strong support for adding behavioral health (including substance use) to the list of Leading Health Indicators in the population health improvement plan;
- Advocating the utilization of county resources (e.g., partner with public health/local agencies/ community groups/stakeholders/school administration, etc.) to galvanize HNJ 2020 activities. This strategy aligns with efforts put forth in New Jersey's Public Health Accreditation activities to accelerate stakeholder engagement and coordination with local public health efforts.
- Widespread need for community level data to inform local programs and policies and challenges with consistency in data collection efforts;
- Enthusiasm for shared learning, best practices, and increased awareness of state and local public health activities;
- Belief in the value of regional stakeholder meetings. The 21 counties of New Jersey are very diverse and population health priorities vary significantly between the northern and southern corridors and the urban and rural geographies.

The Department of Health gained additional stakeholder feedback in the process of applying to the Public Health Accreditation Board, which awarded the Department national accreditation in June of 2017. In response to that input as well as the feedback shared during the SIM Design project, the Department of Health is moving forward to develop strategies for continuing stakeholder feedback and coordination with local health departments. In addition, the Department is exploring ways to enhance online query tools on the DOH website to facilitate greater access to public health data sets. DOH is committed to assuring that policies and initiatives implemented under the population health improvement plan are reflective of the diverse needs of the state's demographic populations, particularly those which are traditionally underserved.

Finally, in order to coordinate population health activities across state government, in 2016 then-Health Commissioner Cathleen Bennett convened the Population Health Action Team, comprising Cabinet officials from seven departments in addition to Health: Agriculture, Children & Families, Community Affairs, Education, Environmental Protection, Human Services and Transportation. As part of its commitment to engaging stakeholders, it held Population Health Summits in September of 2016 and June of 2017 and is committed to continuing them in the future. Its first two population health improvement goals were:

1. To raise awareness of the dangers of lead exposure, using the slogan "No Safe Level of Lead in Children," and
2. To promote optimal nutrition and physical activity, using the slogan "Making the Healthy Choice the Easy Choice."

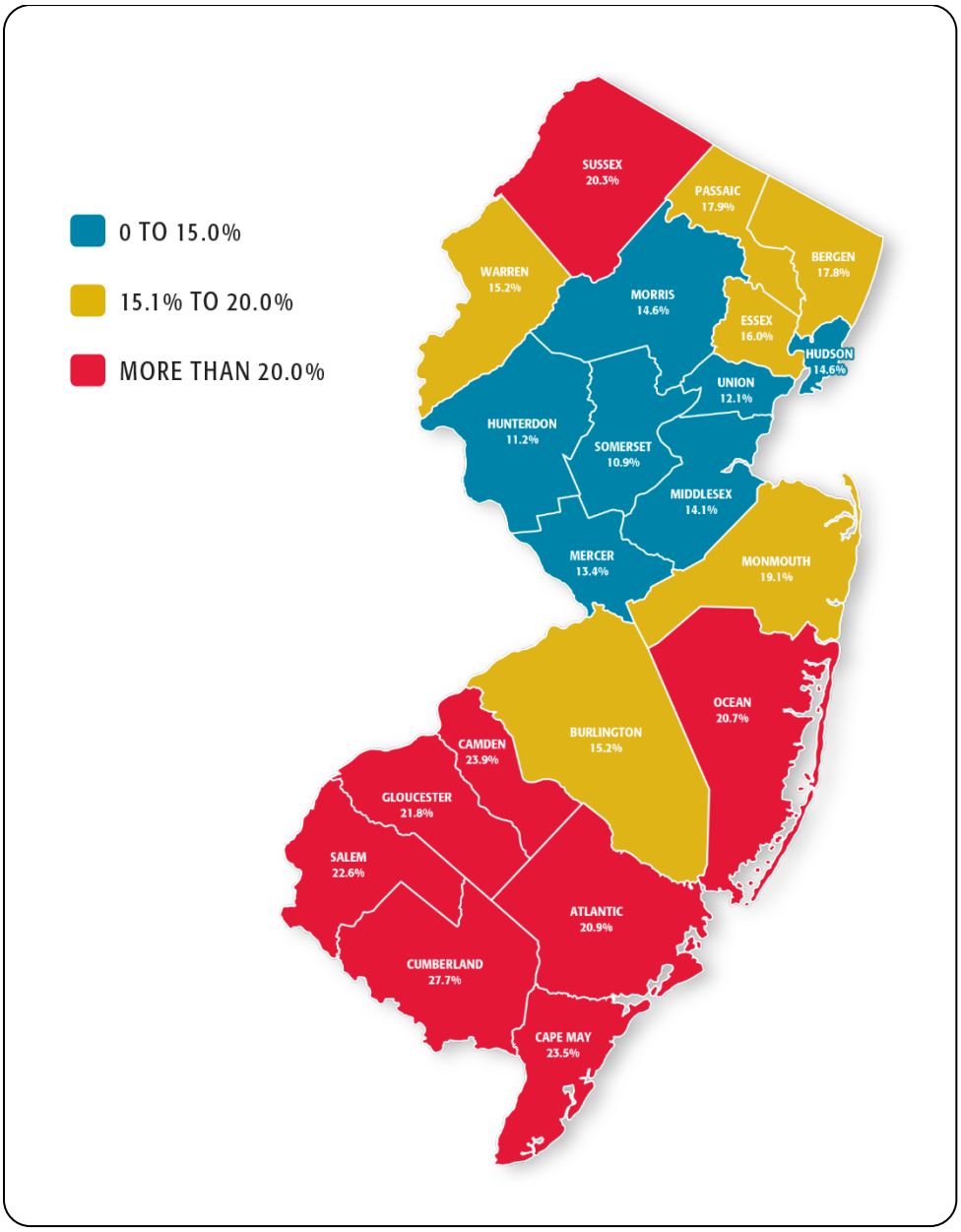
Targeting Population Health Strategies

Tobacco Use in New Jersey

Combatting tobacco use is one of the top priorities of the HNJ2020 plan, with the state's articulated goal of reducing state smoking prevalence to ≤ 13.6% by 2020. Under the NJ SIM, researchers from the Rutgers CSHP team engaged in an extensive analysis of data on smoking prevalence and characteristics of smokers to inform policymaking around smoking cessation efforts and initiatives to improve birth outcomes. Findings from the analysis using the most currently available data from the Behavioral Risk Factor Surveillance System (BRFSS) are described in a brief[38] produced under the NJ SIM and key findings are highlighted here.

[38] Ahmad S, and D DeLia. *Tobacco Use in New Jersey: Variations by Socio-Demographic Characteristics, Region of the State, and Health Insurance Coverage Status*. Facts & Findings. New Brunswick, NJ: Rutgers Center for State Health Policy, 2016. http://cshp.rutgers.edu/Downloads/10930.pdf.

Figure 5: Current Smoking Prevalence by County



Source: New Jersey Behavioral Risk Factor Surveillance System (BRFSS), January 2012–June 2013.

- There is significant geographical variation in smoking prevalence among adults in New Jersey, with higher rates concentrated in the state's southern counties.

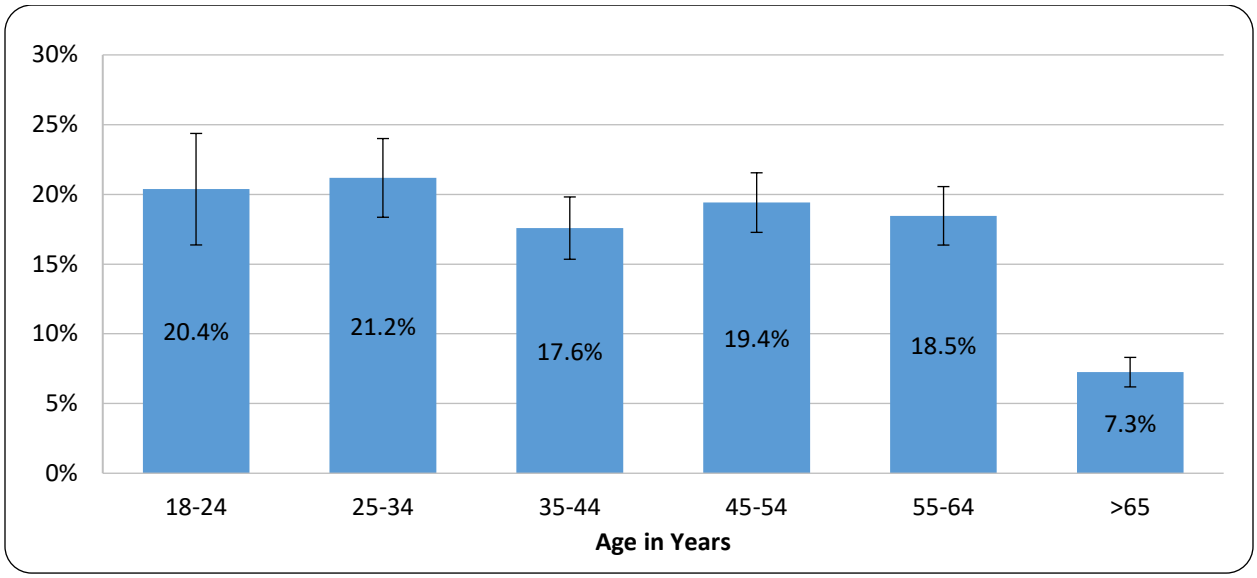
Table 3: Smoking Prevalence by Demographics in New Jersey

Demographic Characteristics	% Who Smoke
Total	17.0%
Gender	
Male	19.6%
Female	14.6%
Marital Status	
Married, Coupled	13.5%
Divorced, Separated	23.3%
Widowed	12.5%
Single, Never Married	23.2%
Annual Household Income	
< $25,000	24.0%
$25,000 to < $50,000	21.4%
$50,000 to < $75,000	17.3%
>$75,000	11.4%
Don't Know or Refused	15.0%
Education	
Did Not Graduate High School	25.1%
Graduated High School	23.4%
Attended College or Technical School	17.9%
Graduated from College or Technical School	8.4%

Source: New Jersey Behavioral Risk Factor Surveillance System (BRFSS), January 2012–June 2013.
Note: Based on sampled adults age 18 and older and tabulations are weighted to account for BRFSS design effects.

- Smoking rate among males is 25% higher than that of females.
- Smoking is correlated with income, with residents who have lower household incomes (under $25,000) having rates that are more than double those of people in households with higher incomes.
- People who have attained only a high school education are three times more likely to smoke than those with a college education or higher.

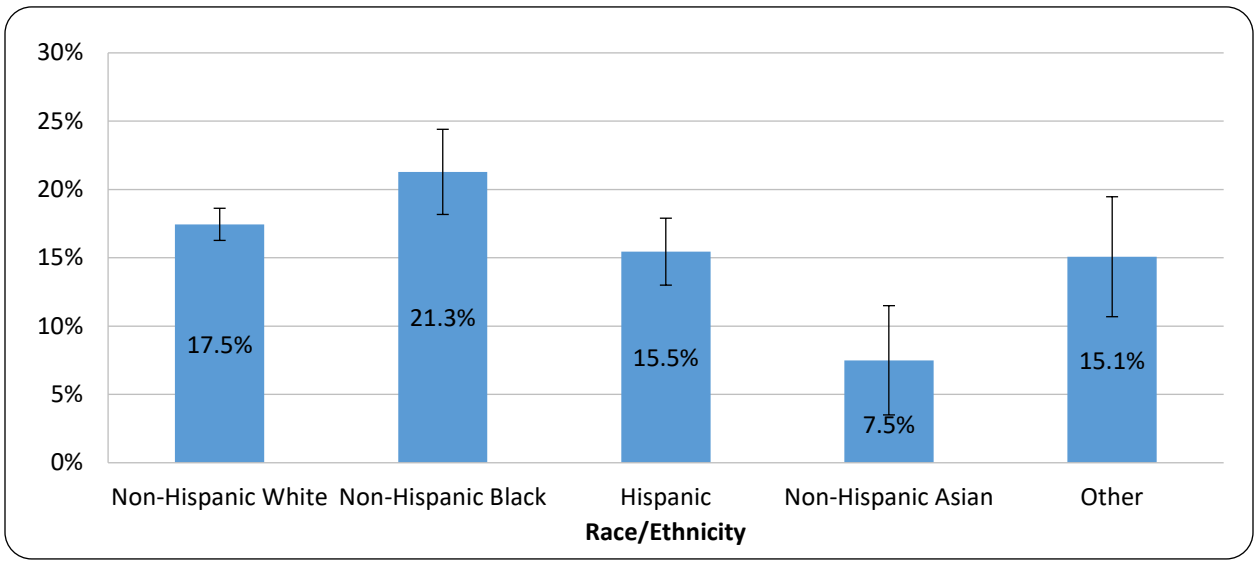
Figure 6: Adult Smoking Prevalence by Age



Source: New Jersey Behavioral Risk Factor Surveillance System (BRFSS), January 2012–June 2013.
Note: Based on sampled adults age 18 and older. Tabulations are weighted to account for BRFSS design effects and 95% confidence intervals are shown.

- Smoking rates vary significantly by age as the rate for the age group 18 to 34 is nearly three times that of older (65 years+) residents.

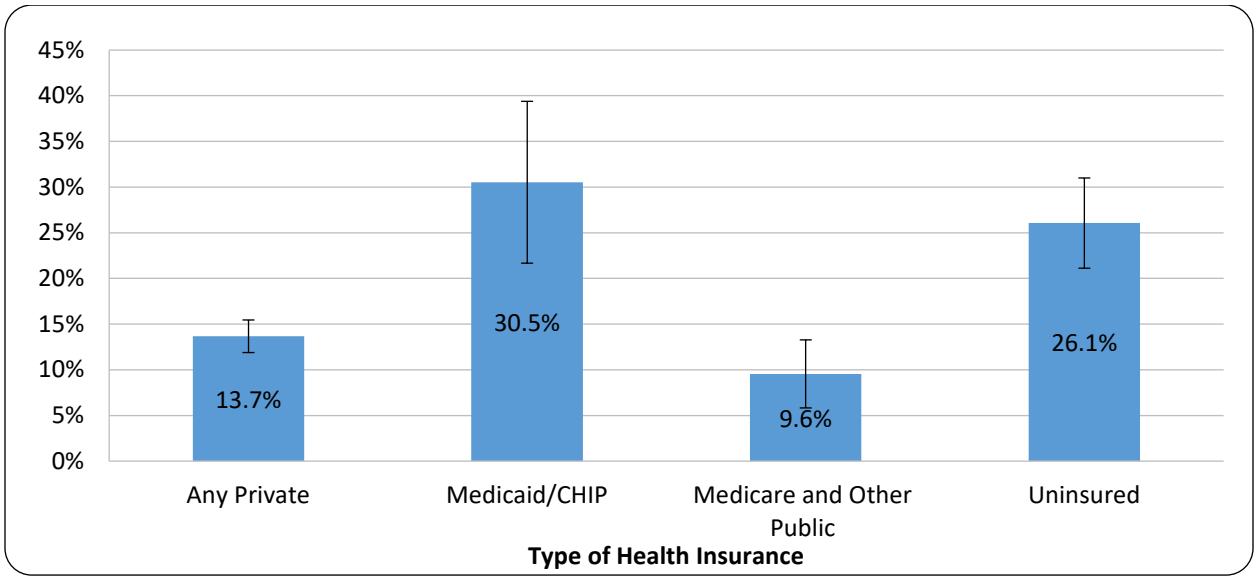
Figure 7: Adult Smoking Prevalence by Race/Ethnicity



Source: New Jersey Behavioral Risk Factor Surveillance System (BRFSS), January 2012–June 2013.
Note: Based on sampled adults age 18 and older. Tabulations are weighted to account for BRFSS design effects and 95% confidence intervals are shown.

- Non-Hispanic blacks have the highest prevalence of smoking (21%), followed by whites (18%), Hispanics (16%) and non-Hispanic Asians (8%).

Figure 8: Adult Smoking Prevalence by Insurance Type



Source: 2009 New Jersey Family Health Survey (NJFHS).
Note: Based on sampled adults age 18 and older. Tabulations are weighted to account for NJFHS design effects and 95% confidence intervals are shown.

- Rates of smoking among Medicaid enrollees are more than twice that for individuals enrolled in private insurance plans.

Utilization of Medicaid's Smoking Cessation Benefits

Among adults enrolled in New Jersey Medicaid, smoking prevalence is nearly 30%, or more than double the rate for those privately insured, with adverse impacts for pregnant women noted below.[39] Although many smokers would like to quit and multiple smoking cessation therapies exist, many of these therapies go unused or discontinued without success.[40]

Given the high rates of smoking in the Medicaid population, Rutgers CSHP used data from the Medicaid Management Information System (MMIS) to describe gaps in the utilization of smoking cessation services for adults (ages 18 and over) in NJ Medicaid. The analysis, which covered service year 2013, also included a focus on subpopulations prioritized under the NJ SIM grant – specifically, pregnant women and individuals with severe mental illness (SMI).

Despite the fact that NJ Medicaid has a comprehensive, multi-pronged benefit package that includes both counseling and pharmacotherapy (i.e., Nicotine Replacement Therapy and Non-

[39] Armour BS, EA Finkelstein, and IC Fiebelkorn. "State-Level Medicaid Expenditures Attributable to Smoking." *Preventing Chronic Disease* 6, no. 3 (2009): A84.
[40] Centers for Disease Control and Prevention. "Quitting Smoking among Adults–United States, 2001–2010." *MMWR. Morbidity and Mortality Weekly Report* 60, no. 44 (2011): 1513–19.

Nicotine Replacement Therapy) to support smoking cessation, across the board there is underutilization of these services. Those enrolled in both the fee-for-service and managed care delivery systems have access to eight of the nine medication and counseling therapies available to treat tobacco use disorder. Medications like Zyban and Chantix, in addition to nicotine replacement therapies including the patch, gum, lozenge, spray and inhaler, are covered. In 2015, the nicotine patch accounted for 62% of smoking cessation drug claims followed by Chantix, which accounted for 26% of claims. While group counseling for tobacco cessation is not available through NJ FamilyCare (Medicaid), individual counseling is a covered benefit. NJ FamilyCare has historically supported these benefits, even prior to changes in federal law requiring states to cover these services for all beneficiaries.

The data show that only 23% of identified smokers in Medicaid utilize either counseling services or pharmacotherapies with only 2.9% pursuing both options, and there seems to be little difference in benefit use by managed care plan enrollment.

Analysis of the data indicate that the challenges that are faced with regard to promoting smoking cessation benefits extend beyond the Medicaid program. Findings from a survey of 2,500 NJ primary care providers (including but not limited to Medicaid physicians) fielded under the NJ SIM found that, among respondent providers, 37% “disagree” or “strongly disagree” that it is easy to secure smoking cessation benefits for their patients. There is also opportunity for smokers to access support through well-established programs sponsored by the NJ Department of Health including NJ Quitline and NJ Mom’s Quit Connection. The NJ SIM Primary Care Practice Survey showed encouraging data that nearly 45% of providers currently refer or plan to refer their patients who smoke to these programs for cessation support.

With regard to the nearly 10% of identified pregnant women on Medicaid with a smoking-related diagnosis code, the rate of use for either of these programs is low (11.3%). While we know that smoking rates for individuals with Serious Mental Illness (SMI) in general are higher than the overall Medicaid population, alarmingly we found that among pregnant women with SMI, 38.2% are identified as smokers. Within that group, only 19% received either counseling and/or pharmacotherapy. These findings present the opportunity to explore policy interventions targeted to pregnant women in order to decrease their smoking rates with the goal of improving birth outcomes.

Interventions to Improve Birth Outcomes

With one of the primary goals of the NJ SIM Design Model being to identify opportunities to improve birth outcomes, the analysis also included an assessment of smoking rates among reproductive age and pregnant women. We know that smoking in pregnant women presents

various threats including increased risk of miscarriage and chances of the baby having various cardiovascular, nervous system, musculoskeletal, and facial defects. We found that among women in New Jersey between ages 18 and 44 years, prevalence of smoking is nearly comparable to the rate for women 44 years and older (15% vs 14%). The encouraging finding was that smoking prevalence reported by pregnant women was more than 50% lower than the rate reported by women who were not pregnant (7% vs 16%).

Colleagues at the Central Jersey Family Health Consortium (CJFHC), who participated on the NJ SIM project team, further examined the evidence in three birth-related datasets, Perinatal Risk Assessment (PRA), Electronic Birth Certificate (EBC), and the Pregnancy Risk Assessment Monitoring System (PRAMS), to help inform the state's policymaking strategy around this issue. Their findings, documented in "*Improving Outcomes through Smoking Cessation,*"[41] show that maternal smoking is also linked to increased risk of pre-term birth, low birth weight, placental abruption, and stillbirth. In addition to the most important implication of smoking which is on the health of the infant, these complications also put significant financial stress on the health care system. The CJFHC report shows that care for babies born prematurely or at low birth weight (i.e., less than 5lb., 8 oz.)[42] costs 12 times more compared to a normal uncomplicated birth. These cost burdens are particularly felt by the Medicaid program given the smoking prevalence in that population.

There are also significant long-term negative health outcomes for these children including, for example, chronic allergies, asthma, type 2 diabetes, and behavioral problems and cognitive delays. The data show that smoking during the post-partum period (a time when many women relapse due to the stress) also places the infant at higher risk for sudden infant death syndrome (SIDS).

In light of the fact that fetal development is affected at the earliest stages of pregnancy, the state is exploring opportunities to advance early prenatal smoking cessation interventions in order to reduce negative birth outcomes.

Strategies for Smoking Cessation in Pregnant Women

Governor Christie has said repeatedly: "No life is disposable." This has meant not only providing pathways to recovery for those struggling with a substance use disorder, but also giving every child the healthiest possible start in life. Examples of the latter include the Governor's

[41] McFarland CAS, R Brogden, R D'Oria, and V Dawson. *Improving Birth Outcomes through Smoking Cessation*. Tinton Falls, NJ: Central Jersey Family Health Consortium, 2016.
[42] March of Dimes. "Low Birthweight." Last modified October 2014. http://www.marchofdimes.org/complications/low-birthweight.aspx.

enactment of New Jersey's first-in-the-nation mandate[43] for pulse-oximetry screening to detect critical congenital heart defects and his expansion of the state's newborn screening program to include 55 metabolic and genetic disorders. New Jersey also applied for and participated in the National Governors Association's Improving Birth Outcomes Learning Network.

In an effort to build upon these and other initiatives, the SIM Steering Committee commissioned The University of Pennsylvania's Center for Health Incentives and Behavioral Economics (CHIBE), led by Dr. Kevin Volpp, to design a program using incentive-based interventions to address smoking among pregnant Medicaid recipients and relapse prevention among new mothers.[44] Colleagues at Penn found that, due to the success of incentives in improving health in a number of contexts, the use of financial incentives to promote health behaviors has been increasing in both the private and public sectors.

Their incentive design proposal is motivated by the data which show that:

- Smoking while pregnant is the most preventable cause of infant morbidity, mortality, and pregnancy-related complications that contribute to higher healthcare costs.
- Incentive programs in the public and private sectors have been used to significantly reduce the occurrence of smoking while pregnant.
- Healthcare costs for the infant extend beyond expenses incurred at birth, especially if the mother relapses or continues to smoke.

As noted above, New Jersey's SIM Design grant was limited to 16 months and to planning and design activities, including consultation with stakeholders. Accordingly, the SIM Steering Committee recognized that a smoking-cessation incentive program could be implemented only after the conclusion of the SIM Design project, using a different funding source, and that this program would best be implemented initially on a pilot basis. Implementing such a pilot program would require:

1. Identifying one or more funding sources to pay incentives and evaluate outcomes. (One possibility would be the next round of federal SIM "Test" grant funding[45], should it be offered. Other possibilities could include foundation funding or quality improvement activities by Medicaid Managed Care Organizations.)
2. Working out the logistics of implementing an incentive program through the Medicaid Managed Care Organizations.

[43] P.L. 2011, Ch. 74

[44] Center for Health Incentives and Behavioral Economics. *Summary of Program of Financial Incentives for Smoking Cessation in Pregnant Woman*. Proposal developed under NJ SIM Design Grant (No. 1G1CMS331386-01-07), 2016.

[45] Federal SIM Test Grants were awarded to implement and evaluation innovation models that already had been developed, typically using SIM Design grants. During the second round of SIM grants, SIM Test grants were available in amounts from $20 million up to $100 million over four years.

3. Identifying a suitable population or geographic area in which to pilot the program.
4. Partnering with a research organization with the expertise to collect data, analyze outcomes and make recommendations on whether to expand or modify the pilot program.

Design of the Pilot Program

Eligible participants in this "two arm" trial (600 women recruited for each arm) will include pregnant women covered by Medicaid in their first or second trimester who report smoking on entry in prenatal care, and who smoke on average five or more cigarettes a day. Eligible participants are expected to be enrolled in Medicaid Managed Care Organizations (MCOs), and the program would be conducted in collaboration with one or more MCOs. Participants will be assigned to one of the two programs randomly to facilitate subsequent assessment of comparative effectiveness.

Overview of Incentive Programs

This randomized control trial would implement two programs deploying different incentive structures to reduce cigarette smoking during and after pregnancy in the NJ Medicaid program.

Incentive Program 1: Fixed Incentive Structure: Participants assigned to this program would receive usual care through their clinicians as well as incentives for verified abstinence. The amount of incentive they receive for verified abstinence will be $75 at each visit. Women will also receive $25 for attending each monthly prenatal visit where samples to verify abstinence can be collected. The maximum potential earnings will not exceed $800, including $600 of contingent incentives for abstinence and $200 for attending the recommended 8 visits with their OB-GYN.

Incentive Program 2: Virtual Deposit Structure: Participants assigned to this program would receive usual care through their clinicians as well as incentives for verified abstinence. The incentives participants earn in this program would come from a pre-funded deposit account in which at the outset of the program pregnant smokers will be notified that $600 has been placed into an account. At each visit at which they do not provide biochemical evidence of abstinence, they will lose a portion of this initial funding, reducing total potential earnings. As in the fixed incentive condition, women will also receive $25 for attending each monthly prenatal visit where samples to verify abstinence can be collected. The maximum potential earnings will not exceed $800: $600 in contingent incentives for abstinence and $200 for attending visits with their OBGYN.

Usual Care Control: In order to accurately measure the effectiveness and cost-effectiveness of the incentive strategies, under the Penn Model a group of 600 women will receive only usual care only and will also receive $25 for attending a visit with their OB-GYN where samples to verify abstinence can be collected.

Postnatal Relapse Prevention Program

With data documenting the impact of second- and third-hand smoke on infants, the Penn model also includes an incentive structure to reduce relapse of post-partum smoking. Eligible participants will include new mothers covered by Medicaid who participated in the prenatal intervention and were tobacco-free at the time of delivery (target 300 women). Participants are expected to be enrolled in Medicaid MCOs and will be assigned to either an incentive relapse prevention program or a usual care/control group. Participants assigned to this program would receive usual care through their clinicians as well as incentives for verified abstinence.

Section 8: Statewide Network of Health Information

New Jersey has some of the most clinically advanced healthcare delivery institutions in the country. Leveraging funding provided under the Health Information Technology for Economic and Clinical Health ("HITECH") Act (part of the 2009 American Recovery & Reinvestment Act [ARRA]), these institutions have built extremely high-functioning, cutting-edge Health Information Networks (HINs), Health Information Organizations (HIOs), Integrated Delivery Networks (IDNs), and other portals to facilitate timely sharing of electronic health data. Though many of the hospitals and provider groups around the state have invested in certified health information resources to improve the quality of patient care and establish localized networks to share information with their providers, the challenges lie with few of these high-powered systems having the ability to exchange data with external systems. Some of the most vexing consequences of these data "silos" include: 1) inadequate systems to reliably and accurately match patients across the continuum of care; 2) significant gaps in interoperability among health systems and, in particular, with small provider practices; and 3) under-developed connections to the public health immunization and other similar state registries.

Under the direction of then-Commissioner Cathleen Bennett, the NJ Department of Health has taken on the leadership role and is responsible for the design and implementation of the next phase of the state's HIT blueprint. The state's HIT strategy has been consistently informed by broad stakeholder input on important topics including privacy and security best practices, technical and data standards, financial sustainability of systems, and quality measurement and reporting. Hospitals, provider organizations, managed care plans, consumer groups, and a wide range of technical consultants have been tapped to contribute to this substantial undertaking.

NJ had three overarching health IT policy goals that, while pre-dating the NJ SIM award, were materially advanced during the tenure of the NJ SIM grant: 1) helping providers in large numbers make the transition to EHRs; 2) continuing high-performing regional HIOs; and 3) development of a statewide Health Information Network (HIN), which has since been implemented and will serve as a gateway to the nationwide HIN. The connection of the major HIOs to the NJ HIN will be a significant achievement and will be used to establish interoperable statewide exchange of electronic medical record health information. This entire structure will be joined together on a shared service platform and will contain master patient and provider indices developed using proven metrics of success which will enhance the quality and coordination of patient care.

In pursuit of these goals, NJ has leveraged a number of policy, legislative, and regulatory levers to accelerate standards-based health IT implementation, including: coordination of a privacy and security subcommittee to identify state health information network recommendations; and developing guidelines for the HIOs to comply with federal privacy and security regulations and to connect with NJ HIN.

With regard to the current landscape in New Jersey, the state has six HIOs which vary widely by several characteristics including geography, business model, and membership.[46] New Jersey's aggressive efforts to overcome interoperability barriers and develop a reliable and accurate platform for patients and providers to share real-time and actionable health information were bolstered by two significant funding awards as the NJ SIM activities were underway. First, in August 2015 the New Jersey Innovation Institute ("NJII" or "Innovation Institute"), NJ's state-designated HITECH entity, received a nearly $3 million award from the Office of the National Coordinator of Health Information Technology (ONC) on behalf of the NJ Department of Health.[47] This award leveraged work already underway to create a Common Key Service (CKS) that will extend to the entire state, and facilitate the connection with the New Jersey Health Information Network (NJHIN). In addition, with this funding the Department of Health (DOH) is moving forward to improve adoption rates of NJ's immunization registry by enabling direct connections through the existing HIOs. This is also an important and linked priority to the State Health Improvement Plan to enhance the use and value of public health registries.

In addition, in February 2016 NJII was selected as one of 39 health care collaborative networks nationally to participate in the *"Transforming Clinical Practice Initiative"* funded by the US

[46] NJ-HITEC. "New Jersey's HIOs." Accessed August 10, 2016. http://www.njhitec.org/index.php/services/hie/nj/.
[47] New Jersey Innovation Institute. "New Jersey Innovation Institute Awarded Federal Grant to Advance Health Information Technology Services." Last modified February 16, 2016. http://njii.com/2016/02/16/new-jersey-innovation-institute-awarded-2-9-million-federal-grant-to-advance-health-information-technology-services-to-support-health-information-exchange/.

Department of Health and Human Services. Under this award, the Innovation Institute can receive up to nearly $50 million to work on the state's behalf to develop a learning network and provide technical assistance to an estimated 11,500 clinicians to enable the efficient transfer of health information and improve the quality of patient care.[48] The technical assistance to primary care providers includes advanced support for implementation of EHRs toward the goal of achieving Meaningful Use (MU), with special emphasis on providers in underserved areas. Transformation activities also include developing security assessment tools, audit preparedness, continuing education and other educational programs, and guidance on regulatory compliance.

In October 2017, leveraging additional funding from HITECH, the Division of Medical Assistance and Health Services' (DMAHS) submitted a health information exchange implementation advanced planning document update (HIE-IAPD-U). The HIE IAPD-U submitted was intended to support the meaningful use of EHR technology by Medicaid providers while enhancing the functionality and usability of the State's HIE infrastructure. The Centers for Medicare and Medicaid Services (CMS) approved the HIE-IAPD-U, with milestone-based federal funding participation that, when achieved, could potentially total $22 million over two years. This funding will support initiatives to improve the efficiency of the NJHIN and on-board Medicaid providers to the HIE to promote provider use of the State's evolving HIE infrastructure, thereby improving the integration and coordination of care for patients throughout the State.

Such robust funding provides substantial opportunity for New Jersey to advance its HIT strategy with intensive provider outreach and support, data driven analytics, and broad stakeholder input. We learned more about the gaps in provider IT capacities from findings from the 2015 SIM NJ Primary Care Practice Survey with responses from 698 providers statewide. While most practices (69%) have more than 90% of their patient records on an EHR, nearly 20% have no EHR. Less than half of practices (41%) received incentive payments for meaningful use of HIT, and over a third of respondents (38.7%) have no specific plans to invest in improving their EHR capacity. Of those with EHRs, the majority of them have electronic access to emergency room visits (60.5%) and hospital discharge summaries (65.8%), but only (36.3%) have electronic access to reports from specialists. The need to enhance the electronic linkages between primary care providers and specialists is a priority for the state's HIT leadership, and has been echoed in other innovative demonstrations across New Jersey, including the CMMI-funded Comprehensive Primary Care initiative.

[48] New Jersey Innovation Institute. "New Jersey Innovation Institute (NJII) Receives $49.6 Million Transforming Clinical Practice Initiative Award." Last modified February 16, 2016. http://njii.com/2016/02/16/new-jersey-innovation-institute-njii-receives-49-6-million-transforming-clinical-practice-initiative-award/.

Another priority in the state's HIT plan that was further advanced under the NJ SIM involved an assessment of the Vital Information Platform (VIP), the Department of Health's electronic birth registration system that was fully implemented in all birthing hospitals in June 2015. The VIP replaced the "legacy" Electronic Birth Certificate (EBC) system in the state. This analysis was undertaken after nearly one year of full implementation in order to assess the overall performance of the VIP, with the additional goals of improving the efficiency and accuracy of the data collection process, and continuing efforts to reduce burdens on providers. The state is continuing to explore ways to enhance linkages of birth data with other sources of electronic health information to guide New Jersey's population health improvement strategy.

Section 9: Evaluation and Monitoring

While a formal evaluation was not a component of the NJ SIM Model Design award work plan, the project team consistently engaged in self-monitoring and assessment activities. This was particularly evident with regard to our stakeholder convening strategy. At the conclusion of each of our stakeholder focused events, including the six NJ DOH *Healthy New Jersey 2020* forums and the two statewide meetings, participants were asked to complete an evaluation survey rating the quality of the meeting and providing feedback to inform the content of future meetings. The feedback collected through the survey was summarized in a memo and submitted to the NJ SIM Steering Committee, the governing body which was responsible for oversight and compliance for all project-related activities.

Appendix A: Roster of Quality Metric Alignment Advisory Committee

Continued on next page.

RUTGERS
Center for State Health Policy

NJ SIM Quality Metrics Alignment Advisory Group
Attendees 4-12-16

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Appendix B: June and November Meeting Agendas

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Invitational Summit

"Paving the Way to Higher Performing Healthcare in New Jersey"
Tuesday, June 23, 2015
9:00 a.m. – 4:00 p.m.
Heldrich Hotel, 10 Livingston Avenue, New Brunswick, NJ

Agenda

9:00 a.m. – 9:30 a.m.	**Breakfast & Registration**
9:30 a.m. – 9:45 a.m.	**Welcome & Introduction** Margaret Koller, Executive Director, Rutgers Center for State Health Policy Bob Schwaneberg, Policy Advisor for Health Care, Office of Gov. Chris Christie
9:45 a.m. – 10:15 a.m.	**Overview of Federal Objectives & Initiatives for Transforming Healthcare** Jackie Cornell-Bechelli, Region II Director, U.S. Department of Health & Human Services
10:15 a.m. – 10:45 a.m.	**New Jersey Health Care Delivery: Where Do We Stand?** Joel Cantor, Distinguished Professor & Director, Rutgers Center for State Health Policy
10:45 a.m. – 11:45 a.m.	**The Road to Innovation: An Update on New Jersey's Health & Healthcare Initiatives and Q & A** Mary E. O'Dowd, Commissioner, NJ Department of Health (10:45 a.m. – 11:15 a.m.) Elizabeth Connolly, Acting Commissioner, NJ Department of Human Services (11:15 a.m. – 11:45 a.m.)
11:45 a.m. – 12:45 p.m.	**Luncheon – Christopher's Restaurant** Sponsored by The Nicholson Foundation | Advancing Health and Promoting Opportunity
12:45 p.m. – 1:30 p.m.	**Introduction to Keynote Speaker** Terry Shlimbaum, Chief, Adult Primary Care Service & Physician Integration, Summit Medical Group **Keynote Address** Paul Grundy, Founding President, Patient-Centered Primary Care Collaborative & Global Director, Healthcare Transformation, IBM

1:30 p.m. – 2:15 p.m. **Advancing Healthcare Transformation in New Jersey: Perspectives from the Field**

Moderator
Russ Molloy, Senior Vice President, Government Relations, Meridian Health

Panelists
- Robert Eidus, President, Vanguard Medical Group
- Steven R. Peskin, Senior Medical Director, Clinical Innovation, Horizon Blue Cross Blue Shield of New Jersey
- Robert Remstein, Vice President, Accountable Care, Capital Health
- Susan Walsh, Vice President Community Medicine, ACO Medical Director, Jersey City Medical Center

2:15 p.m. – 2:30 p.m. **Break**

2:30 p.m. – 3:30 p.m. **Integration of Physical & Behavioral Health**

Overview of Relevant Licensure & Reimbursement Considerations
John Jacobi, Dorothea Dix Professor of Health Law & Policy, Faculty Director of The Center for Health & Pharmaceutical Law & Policy, Seton Hall School of Law

Emerging Integration Models in New Jersey

Moderator
John Jacobi

Panelists
- Joe Hicks, President & CEO, Barnabas Health, Behavioral Health Services
- Mark Humowiecki, Counsel & Director, Government Affairs, Camden Coalition of Healthcare Providers
- Steve Levin, Associate Professor, Department of Family Medicine & Community Health, Robert Wood Johnson Medical School & Medical Director, Eric B. Chandler Health Center
- John Monahan, President & CEO, Greater Trenton Behavioral Healthcare

3:30 p.m. – 4:00 p.m. **Closing Remarks**

Acknowledgements – Hosted by Rutgers Center for State Health Policy, a Unit within the Institute for Health, Health Care Policy and Aging Research. Support for this meeting provided by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, State Innovation Model (SIM) Design Award #1G1CMS331386-01. Luncheon sponsored by The Nicholson Foundation. Additional support provided by the Robert Wood Johnson Foundation.

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Invitational Summit

"Advancing Delivery System Transformation in NJ"
Thursday, November 19, 2015
8:30 a.m. – 4:00 p.m.
Heldrich Hotel, New Brunswick, NJ
Agenda

8:30 a.m. – 9:00 a.m. **Breakfast & Registration (1st Floor Lobby)**

9:00 a.m. – 9:15 a.m. **Welcome & Opening Remarks (Livingston Ball Room 1 & 2)**
Bob Schwaneberg, Policy Advisor for Health Care, Office of Governor Chris Christie
Margaret Koller, Executive Director, Rutgers Center for State Health Policy

9:15 a.m. – 10:00 a.m. **NJ SIM Project Updates & Plans (Livingston Ball Room 1 & 2)**
Michelle Pichardo, SIM Project Director, Rutgers Center for State Health Policy
Joel C. Cantor, Distinguished Professor & Director, Rutgers Center for State Health Policy

10:00 a.m. – 10:15 a.m. **Break**

10:15 a.m. – 12:00 p.m. **Achieving Delivery System Transformation (Livingston Ball Room 1 & 2)**

Moderator
Heather Howard, Director, RWJF State Health & Value Strategies Program, Princeton University

Presenters (10:15 a.m. – 11:15 a.m.)

- Christopher F. Koller, President, Milbank Memorial Fund
- Joseph W. Manger, Director, Regulatory Affairs/Government Programs, Horizon NJ Health
- Harold Miller, President & CEO, Center for Healthcare Quality & Payment Reform
- Lewis Sandy, Executive Vice President, Clinical Advancement, UnitedHealth Group

Facilitated Panel Discussion (11:15 a.m. – 12:00 p.m.)

12:00 p.m. – 12:45 p.m. **Networking Luncheon (Livingston Ball Room 1 & 2)**

1:00 p.m. – 2:30 p.m. **Concurrent Breakout Sessions**

Strategies to Improve Behavioral Health Integration (Livingston Ball Room 1 & 2)

Discussion Leader
John Jacobi, Dorothea Dix Professor of Health Law & Policy, Faculty Director of The Center for Health & Pharmaceutical Law & Policy, Seton Hall School of Law

Presenters

- Janet Duni, Director of Care Coordination, Vanguard Medical Group
- Joseph A. Masciandaro, President & CEO, CarePlus NJ
- Rosemarie Rosati, Chief Operating Officer, Rutgers University Behavioral Health Care

Addressing Care Coordination Priorities for Vulnerable Populations (Livingston Ball Room 3)

Discussion Leader

Eric Jahn, Senior Associate Dean for Community Health, Rutgers Robert Wood Johnson Medical School

Presenters

- Mark Humowiecki, General Counsel & Director of External Affairs, Camden Coalition of Healthcare Providers
- Gail Reilly, Medical Director, Parker Family Health Center
- Jennifer N. Rosen Valverde, Clinical Professor of Law, Education & Health Law Clinic Legal Director, H.E.A.L. Collaborative, Rutgers University School of Law

Building a Healthcare Workforce to Advance Delivery System Transformation (Livingston Ball Room 4)

Discussion Leader

Jeanne Ferrante, Professor, Department of Family Medicine & Community Health, Research Division, Rutgers Robert Wood Johnson Medical School

Presenters

- Deborah Briggs, President & CEO, New Jersey Council of Teaching Hospitals
- Edna Cadmus, Director Nursing Leadership Program, Rutgers University & Executive Director, New Jersey Collaborating Center for Nursing (NJCCN)
- Steve Landers, President & CEO, Visiting Nurse Association Health Group
- Robert P. Wise, President & CEO, Hunterdon Healthcare & Chair of the New Jersey Health Care Workforce Council

2:30 p.m. – 2:45 p.m. **Break**

2:45 p.m. – 3:45 p.m. **Next Phase of Innovation in New Jersey (Livingston Ball Room 1 & 2)**

Facilitator

Joel C. Cantor, Distinguished Professor& Director, Rutgers Center for State Health Policy

Discussants

- Evelyn Liebman, Associate State Director for Advocacy, AARP
- Alfred Tallia, Professor & Chair, Family Medicine & Community Health, Rutgers Robert Wood Johnson Medical School
- Jennifer Velez, Senior Vice President of Strategy & Planning, Barnabas Health System

3:45 p.m. – 4:00 p.m. **Closing**

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