MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

New Jersey State Police Headquarters Complex
Public Health, Environmental and Agricultural
Laboratory Building
3 Schwarzkopf Drive
Ewing Township, New Jersey 08628

October 19, 2015
10:00 A.M.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:
Deborah Spitalnik, PhD, Chair
Sherl Brand
Theresa Edelstein
Dorothea Libman
Beverly Roberts

MEMBERS EXCUSED:
Mary Coogan
Eileen C. Coyne
Dennis Lafer
Wayne Vivian
Sidney Whitman

STATE REPRESENTATIVE:
Valerie Harr, Director
Division of Medical Assistance and Health Services

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Slide presentations conducted at Medical Assistance Advisory Council meetings are available for viewing at http://www.state.nj.us/humanservices/dmahs/boards/maac/

ATTENDEES:

Evelyn Liebman	AARP
Dan Keating	Alliance for the Betterment of Citizens with Disabilities
Cathy Chin	Alman Group
Michelle Jaker	Amerigroup
Tom Grady	Brain Injury Alliance of New Jersey
Shabnam Salih	Camden Coalition of Health Care Providers
Gwen Orlowski	Legal Services of Central Jersey
Kimberly Salomon	Community Health Law Project
Mary-Catherine Bohan	Community Care Behavioral Health Organization
Lolita Allen	Consumer
Susan Saidel Deborah	Disability Rights New Jersey
Cox	Gloucester County Department of Social Services
John Indyk	Health Care Association of New Jersey
Tom Dorner	Health Care Association of New Jersey
Frank DiGiovanni	Healthplex
Chrissy Buteas	HomeCare Hospice Association of New Jersey
Joseph Manger	Horizon NJ Health
Emily Holmes	Indivior, PLC
Phil Lachaga	Johnson & Johnson
Marylou Pardey	Katz Government Affairs
Christine Fares Walky	LIFE St. Francis
Barbara Dunn	Magellan Health Care
Eric Aronowitz	Mercer County Board of Social Services
Amanda Shuber	Medical Society of New Jersey
Virginia Nelson	Middlesex County Board of Social Services
Amanda Cortez	Medical Transportation Association of New Jersey
Maureen Shea	NJ Association of Community Providers
Mary Abrams	NJ Association of Mental Health and Addiction Agencies
Shauna Moses	NJ Association of Mental Health and Addiction Agencies
Debra Wentz	NJ Association of Mental Health and Addiction Agencies
Maura Collinsgro	NJ Citizen Action
Paul Blaustein	NJ Council on Developmental Disabilities
Kevin Casey	NJ Council on Developmental Disabilities
Stephanie Pratico	NJ Council on Developmental Disabilities

ATTENDEES:

Name	Affiliation
Dennie Todd	NJ Council on Developmental Disabilities
Grace Egan	NJ Foundation for Aging
Kate Clark	Family Planning Association of New Jersey
Amanda Melillo	New Jersey Health Care Quality Institute
Selina Haq	NJ Primary Care Association
Andrew Kitchenman	NJ Spotlight
Judy Jenkins	Otsuka Pharmaceutical Co., Ltd.
Sonia Delgado	Princeton Public Affairs Group, Inc.
Mary Kay Roberts	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Kathleen Lockbaum	Salem County Welfare Agency
Deepa Srinivasawaradan	Statewide Parent Advocacy Network
Rachael Jeffers	The Nicholson Foundation
Julie Caliwan	The Innovation Collaborative
Kim Todd	The Innovation Collaborative
Michael Simone	UnitedHealthcare
Zinke McGeady	Values Into Action NJ
Lisa Knowles	WellCare
Dave Weber	Xerox Government Healthcare
Nicole McKnight	Centers for Medicare & Medicaid Services
Maria Varon	Centers for Medicare & Medicaid Services
Desmond Webb	NJ Department of the Treasury
Dawn Apgar	NJ Department of Human Services
Frieda Phillips	NJ Department of Human Services
Ian Zapac	NJ Department of Human Services
Nancy Day	NJ Division of Aging Services
Valerie Mielke	NJ Division of Mental Health and Addiction Services
Liz Shea	NJ Division of Developmental Disabilities
Stephen Myers	NJ Division of Medical Assistance and Health Services
Jodie Flandinette	NJ Division of Medical Assistance and Health Services
Carol Grant	NJ Division of Medical Assistance and Health Services
Roxanne Kennedy	NJ Division of Medical Assistance and Health Services
Thomas Lind	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services

ATTENDEES:

Joshua Lichtblau	NJ Office of Legislative Services
Robin Ford	NJ Office of Legislative Services
James McCracken	NJ Office of the Ombudsman for the Institutional Elderly

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1 CHAIRWOMAN SPITALNIK: Good morning.
2 Welcome to the Medical Assistance Advisory Council (MAAC)
3 meeting of Monday, October 19th.
4 We celebrate two things today: Breast
5 cancer awareness month. And I thank all of you for all
6 you do to promote women's health and everyone's health.
7 We also will recognize at the end of the meeting the 50th
8 anniversary of Medicaid and Medicare and read the
9 resolution that was passed by the New Jersey Senate.
10 We're not going to do that right now because some of our
11 speakers are pressed for time.
12 I'm Deborah Spitalnik. I'm the Chair of the
13 MAAC. And one of the things I need to do is to let you
14 know some of the emergency procedures, which I'm sure we
15 won't have to use, but to let you know in keeping with
16 the requirements of this building, if you hear the fire
17 alarm or evacuation announcement, quickly leave the
18 building by the nearest exit, go to Lamp Post No. 9 in
19 the parking lot. Once there, you'll report to Valerie
20 Harr or Phyllis Melendez who will check off your names on
21 the attendance sheet. Please wait in that designated
22 area for additional instructions.
23 Our typical pattern, which we will, of
24 course, do today is I'll ask the members of the MAAC to
25 introduce themselves, I'll ask the members of the public

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1 to introduce themselves. We have always been able to
2 have free-flowing discussion at this meeting. Some
3 councils and committees isolate public comment to a
4 particular period. We try to do it in the context of the
5 presentation so that we have a full discussion of issues.
6 But what I would ask is that the Members of the MAAC are
7 entitled to ask questions and make comments first. From
8 the audience, I'd ask people who ask questions and to
9 keep them brief.
10 We have a big agenda. We don't have a
11 quorum today, so we will not address the minutes from our
12 last meeting. But with that, let me ask Members to
13 introduce themselves.
14 (Members of the MAAC introduce themselves.)
15 (Members of the public introduce themselves.)
16 CHAIRWOMAN SPITALNIK: Welcome, everyone,
17 and thank you so much for being here.
18 We're going to move right into the
19 informational updates. And the first three come from
20 Assistant Commissioner Valerie Mielke. I'm delighted to
21 welcome Valerie who is appointed Assistant Commissioner
22 of the Division of Mental Health and Addiction Services
23 in July. Previous to her present role, she was Assistant
24 Director of the Office of Treatment and Recovery Support.
25 She's an MSW from Rutgers, so I'm particularly delighted

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1 to welcome her. And we're delighted she's in her role,
2 and we look forward to her presentation and to working
3 together.
4 Valerie.
5 MS. MIELKE: Thank you. Thank you very
6 much, Dr. Spitalnik.
7 So for the first item in terms of updates
8 that I wanted to talk to you about is the Interim
9 Managing Entity (IME). And that's the entity whose
10 services that are actually operated by University
11 Behavioral Health Care. And they are currently managing
12 or substance use disorder treatment services. And
13 primarily what they're doing right now is accepting calls
14 from individuals, and they're providing referrals and
15 linkages to services. They are identifying funding
16 sources so that we can best make available and use of our
17 Medicaid resources so that we can ensure that our State
18 resources are really being utilized for those who don't
19 have insurance.
20 One of the functions of the IME is to do
21 extension requests. So if individuals are in services
22 and they need a longer length of time for treatment and
23 services, they can go to the IME and request an
24 extension. The dollars that currently the IME is
25 managing includes our Substance Abuse Block Grant

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1 dollars, our DUI funding, as well as our Medicaid
2 funding. What is not a part of the IME are initiatives
3 under Drug Court, our State Parole Board, and Department
4 of Corrections under our Mutual Agreement Program.
5 In the spring of 2016, we anticipate that
6 the IME will begin to do prior authorizations for
7 services. So as individuals are looking to access
8 services, that the IME will prior authorize those serves.
9 That's my update regarding the IME.
10 In terms of the Mental Health Block Grant,
11 our Mental Health Block Grant is just about $13 million.
12 The block grant, which is issued through the Substance
13 Abuse Mental Health Services Administration, also known
14 as SAMHSA, they support ambulatory services, such as our
15 wellness centers which are operated by individuals who
16 are in recovery; help to support our evidence-based
17 practices, such as our Illness Management and Recovery
18 Programs, our PATH, which is our homeless outreach
19 programs; the services provided in support of housing;
20 integrated dual diagnosis treatment, that's treatment for
21 individuals who have a dual diagnosis of a mental illness
22 and a substance disorder; case management services; our
23 programs for assertive community treatment; and our
24 intensive family support services, to start.
25 The dollars that are awarded to us through

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1 the block grant, we actually award into our agencies in
2 the way of a deficit funded contract. So what that means
3 is that those services are not managed by a third party,
4 but they are a part of our agency's contracts to
5 administer the programs.
6 In terms of the IME, I think questions came
7 up as to whether or not the IME were also folding
8 in mental health services into the Interim Managing
9 Entity. And the only mental health service that will go
10 under the IME is Community Support Services. That's a
11 service that currently does not exist here in New Jersey,
12 but there are currently regulations that Medicaid, as
13 well as Division of Mental Health and Addiction Services,
14 program regulations that are posted. The public comment
15 period has just ended for those draft regulations, and we
16 anticipate that early in Calendar Year 2016 those
17 regulations will be promulgated, and at that point we'll
18 commence Community Support Services.
19 The IME will process prior authorization
20 for service, so they will not be determining whether or
21 not an individual should be enrolled in Community Support
22 Services, but once an individual's enrolled, they will
23 prior authorize the ongoing services. So we don't have
24 any other plans for any other mental health services to
25 be folded under the IME.

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1 In terms of the redesign of mental health
2 and stakeholder input, so one of the things that we have
3 been undergoing for a period of over a year now is a rate
4 study analysis, looking at the current rates that are
5 supporting our services, looking at our Medicaid rates,
6 as well as the cost for providing services that are
7 incurred by the State. That rate study analysis is
8 coming close to conclusion at this point in time. And so
9 hopefully, in the next few months we'll be able to share
10 with you what those rates will be.
11 We had a very extensive stakeholder process
12 to help inform the assumptions that go into the
13 development of the rates. And so once the rates are
14 public, then we will roll them out to the public as well,
15 to our stakeholders.
16 Also, with regard the Administrative Service
17 Organization (ASO) Request for Proposal (RFP) that was
18 developed, we are now in the process at the department
19 level of determining how we are going to move forward in
20 terms of managing services.
21 That's all I have.
22 CHAIRWOMAN SPITALNIK: Thank you so much.
23 Are there questions from the MAAC?
24 Beverly.
25 MS. ROBERTS: Hi. I'm Beverly Roberts with

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1 the Arc of New Jersey, and I don't think I've met you
2 yet. Very pleased to meet you.
3 MS. MIELKE: Nice to meet you.
4 MS. ROBERTS: My question -- and I don't
5 know that you have an answer yet, but I just wanted to
6 sort of put it out there -- is that currently the
7 Behavioral Health Services for folks who have a
8 developmental disability and are served by the Division
9 of Developmental Disabilities (DDD), they're the only
10 group that are having their behavioral health services
11 through the Medicaid health plans. So I didn't know if
12 you had any information on the future of those services
13 or if that is something that you would be recording in
14 the future?
15 MS. MIELKE: Actually, I'd like to defer
16 that question to my colleague Liz Shea who will be
17 following me. Liz can probably speak more to the DDD
18 services.
19 MS. HARR: Behavioral Health is carved in
20 for Managed Long Term Services and Supports (MLTSS).
21 MS. MIELKE: Valerie Harr mentioned that
22 Managed Long Term Services and Supports, behavioral
23 health is carved into the managed care organizations
24 (MCOs) under MLTSS.
25 CHAIRWOMAN SPITALNIK: Brief questions from

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1 anyone in the audience?
2 Yes. Could you please state your name?
3 MS. JEFFERS: Hi, I'm Rachael Jeffers with
4 The Nicholson Foundation. I just have a quick question.
5 You mentioned that new rates were going to be public
6 soon. Do you have a timeline for when those new rates
7 will be in effect after their publication date? And are
8 they rates across the board for State-funded services and
9 Medicaid-funded services?
10 MS. MIELKE: In the terms of the rate study,
11 the rates that we're looking at are both for state-funded
12 services as well as our Medicaid services. We don't have
13 a date as of yet once those rates are rolled out when
14 they will be affected. I think we'll probably have more
15 information once we have the rates that are out.
16 CHAIRWOMAN SPITALNIK: Maura.
17 MS. COLLINSGRO: Maura Collinsgro, New
18 Jersey Citizen Action.
19 I just had a question in terms of the
20 Interim Managing Entity. They're fielding calls now? Do
21 you or will you have in the future a report on volume of
22 calls?
23 And also you mentioned that you're trying to
24 find sources of funding for individuals who don't have
25 insurance. Is there any way that you've operationalized

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1 a procedure to make sure those people get enrolled in
2 insurance either through Medicaid or the Marketplace.
3 MS. MIELKE: Thank you for those questions.
4 So in terms of the volume, we're currently
5 seeing between 3 and 400 calls a day to the IME, about
6 6500 calls a month.
7 In terms of getting individuals enrolled, so
8 it is our expectation that our providers, that the
9 providers that are under contract with us, also enroll in
10 Medicaid if they are providing a service that is Medicaid
11 reimbursable. So the expectation is that then so as
12 individuals are Medicaid-eligible then there will be a
13 drawdown of those Medicaid dollars.
14 So if the consumer does not have Medicaid,
15 then we have our block grant dollars and State dollars
16 that then will be drawn upon to enable individuals to
17 access the services. Those resources, of course, are
18 finite, but we're trying to really maximize the
19 utilization of those services by ensuring that
20 individuals who are Medicaid-eligible that we are
21 actually drawing down the Medicaid dollars for these
22 individuals.
23 MS. COLLINSGRO: For those who aren't, do
24 you have a way to refer them to getting insurance
25 otherwise if they're not Medicaid-eligible? Are you

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1 trying to connect them to the Affordable Care Act (ACA)
2 plans?
3 MS. MIELKE: So the IME is not specifically
4 linking individuals to Medicaid if they are not already,
5 but the expectations of the providers that they enroll
6 with will work to get them enrolled in Medicaid.
7 CHAIRWOMAN SPITALNIK: Valerie, thank you so
8 much. And again, welcome, and we look forward to hearing
9 from you at our next meeting.
10 MS. MIELKE: Thank you very much. Thank you
11 for having me.
12 CHAIRWOMAN SPITALNIK: Thank you so much for
13 being here.
14 I'm delighted to introduce Assistant
15 Commissioner Liz Shea. Liz is the Assistant Commissioner
16 for the Division of Development Disabilities who will
17 speak to us about The Supports Program.
18 MS. SHEA: Good morning, everyone.
19 Since the last time I was here, which I
20 don't think was your last meeting, but maybe it was the
21 meeting prior to that, there's been a lot of change with
22 regard to The Supports Program. Again, because this
23 audience is always a little diverse, I'm just going to
24 give a quick background so you know what I'm talking
25 about.

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1 The Supports Program is DDD's initiative in
2 the Comprehensive Medicaid Waiver. It's basically a
3 complement to what we have already in our system and has
4 had since the '80s, which is called the Community Care
5 Waiver (CCW), which is the way we currently and have for
6 years provided services to the people that needed
7 institutional level of care in the community. So this
8 waiver is sort of a complement to that. It will
9 ultimately allow us to put everybody in our service
10 delivery system into a Medicaid waiver, which has a lot
11 advantages. One of largest, of course, being that we can
12 maximize federal dollars for all the services we provide,
13 thus providing enhanced budgets for people over time,
14 being able to provide more service, to more people.
15 We really began implementation work on it
16 from the date that really it was submitted, but certainly
17 the date that the Comprehensive Waiver was approved in
18 late 2012. In 2013, we began an implementation phase,
19 but that did not include formal enrollment of individuals
20 into the waiver until much more recently due to the fact
21 that it took a lot of system reform to get us there.
22 So anybody familiar at all with the DDD
23 system and what's been happening over the last three,
24 four, five years, know that we've been in a period of
25 great change. Our eligibility regulations changed to

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1 include Medicaid. That was a big piece of it. We did a
2 rate study along with my partner, Val, from the Division
3 of Mental Health and Addiction Services. So we're going
4 to be shifting into a fee-for-service system for our
5 providers. They're all having to become Medicaid
6 providers. We have enhanced services. We're an
7 employment first state. We have a new assessment tool.
8 We have a new service planning process. So, like I said,
9 there's a lot of change all happening. So we've been
10 kind of rolling it in piece by piece over the last couple
11 of years.
12 The good news is with regard to The Supports
13 Program specifically is that we did actually begin
14 formalized enrollment this past July. We started with a
15 small cohort of people to make sure that we were keeping
16 it small enough groups so that we knew if issues arose we
17 had it in a controlled environment. So we call that
18 Cohort 1, it's about a hundred or so people with a small
19 number of providers and a little over a dozen are support
20 coordination agencies who were enrolled at that period of
21 time.
22 Even before we did formal enrollment, we
23 established a small advisory committee which includes
24 individuals that are in the program, families of
25 individuals that are in the program, providers, and

1 support coordination agencies, as well as high level DDD
2 staff. We have bi-weekly calls to discuss what's
3 happening, how it's working, how it's not.
4 I will tell you at the time when we
5 announced the establishment of the advisory committee, I
6 think there was a lot of interest from a lot of other
7 members of the public to be on the advisory committee.
8 We have avenues for that and some other things we'll be
9 putting out soon. But this, we really wanted to limit it
10 to people in the program because we wanted it to be
11 something we could talk about exactly what's happening in
12 the program as opposed to kind of a larger issue. That's
13 been working really, really well.
14 We had a fairly seamless process early on in
15 enrollment in terms of prior authorizations and the
16 service planning piece. We did run into some issues on
17 the Medicaid claiming side for some of our providers, and
18 we're still working our way through those. Now we're
19 meeting regularly and very collaboratively with Medicaid
20 and Molina to get those worked out.
21 The two primary issues which you may or may
22 not have heard of that we ran into so far, one had to do
23 with anybody with secondary insurance. So the way the
24 system had been coded was that anybody that was in The
25 Supports Program and therefore had Medicaid but also had

1 a secondary health insurance of whatever kind, their
2 claims were getting kicked back. The provider wasn't
3 able to bill. There's a variety of reasons why that was
4 happening. We are making sure providers were getting
5 paid in the meantime and we're working with Medicaid to
6 get that corrected. We thought it was actually
7 completely corrected. Late last week I found out there
8 were still a couple getting kicked back, so it seems as
9 though there's still a little glitch. So we're working
10 on that now. We think it's very, very soon to be fully
11 resolved.
12 The other one happened to do with one of our
13 services, which one of the services in The Supports
14 Program is called Pre-vocational Training. And for some
15 reason, based on a code that somebody thinks was maybe in
16 there for ten years ago in the Medicaid system, there was
17 a limit that any claim above 35 units of that service
18 that a provider put in for some reason was getting kicked
19 out. No one knows why. It was some old code. So,
20 again, we're working closely with Medicaid in order to
21 figure out what that is and get that resolved.
22 The things I just talked about is why we
23 kept the original cohort small and we're moving slowly.
24 We need to make sure that we've got everything in place
25 before we go larger. As soon as we have those things

1 resolved, we're looking to begin Cohort 2, which, again,
2 I had hoped originally would be a larger group, but I
3 think given the fact that we still have some things we're
4 working through, we're going to keep that relatively
5 small again. If it's more seamless this time and things
6 go through more quickly, then our next cohort after that
7 can be larger. It's exciting. It's working well for the
8 people that are in it. We just have to work through some
9 of these kind of glitchy things.
10 I will just talk real quickly about one
11 other piece of this, which is our amendments. And I
12 think I spent a little bit of time on that topic the last
13 time I was here. So even before we began enrolling
14 people in The Supports Program, we had identified a
15 series of amendments that we wanted to make to the
16 language. Some of them were small, just kind of
17 technical things that were not hard to do that we just
18 worked with Medicaid and were being submitted. But a
19 couple of them were more significant, and we actually had
20 to work for a fairly lengthy time with both Medicaid,
21 with the Office of Aging, kind of in our own system with
22 MLTSS and with our federal partners to figure out
23 technically how to make them work.
24 So those amendments, they were submitted,
25 the three of them. And I'll talk about what they are.

1 They were submitted back in the summer to the Centers for
2 Medicare and Medicaid Services (CMS) formally after a lot
3 of technical assistance, et cetera. I think the deadline
4 for them to get back to us is November 2015. And we're
5 working very, very closely with Medicaid so that we will
6 be, and we are planning right now, to be ready to
7 operationalize them, expecting they will be approved, and
8 ready to be operationalized at the beginning of the 2016.
9 It's looking very good for that.
10 So those three amendments, for anyone who's
11 not familiar, one of them has to do with - we have a
12 small number of people that age out of our school system
13 on an annual basis who require private duty nursing(PDN),
14 that level of service. In New Jersey, private duty
15 nursing is carved into MLTSS, the Managed Long Term
16 Services and Support system, in the Comprehensive Waiver.
17 But the way the Supports Program is written, you can't be
18 in The Supports Program at DDD so you can get employment
19 and day, et cetera, other services from the Division and
20 also be in MLTSS at the same time. So, again, it's a
21 very small number of people, but these are individuals
22 who could very much benefit from employment and day
23 supports from the Division of Developmental Disability
24 through The Supports Program but require PDN.
25 So we worked closely, again, with Medicaid

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1 as well as with CMS. I'm figuring out what to make that
2 look like and design an amendment to our Supports Program
3 language which will allow, once approved, individuals to
4 be on The Supports Program and simultaneously access just
5 the PDN service out of the MLTSS system.
6 So, again, as you may be able to imagine,
7 there's a lot of technical issues that has to be worked
8 out with that. You've got various codes and a different
9 divisions all working on things. So we're working
10 through that process now. But we should be ready to
11 operationalize that as soon as we get final approval.
12 So that's very exciting. For that small
13 group of people, we've gotten many, many, many, many
14 thank you letters, people in the community are very much
15 in support of that particular amendment, so we're happy
16 about that. And we'll be even happier when the actual
17 approval comes in. We're happy that we think it will.
18 And the other two amendments had to do with
19 new eligibility groups. Again, I talked about this last
20 time, too. As we work through some of our general
21 reform, we identified a couple of issues with people with
22 developmental disabilities being able to get into the
23 Medicaid system and, therefore, get their DDD supports.
24 One of them was this group that we affectionately have
25 deemed internally -- this is not a technical term, but

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1 internally we call them the non-DACs, (non-Disabled Adult
2 Children), and that's a group of people who typically
3 because a parent died before they turned 18, they were
4 never able to get their SSI. Had they been able to get
5 on SSI and their parent died when they were older, the
6 fact that they got an SSDI benefit from their parent,
7 they would have become what's called a disabled adult
8 child and, therefore, they would have kept their
9 Medicaid. Because their parent happened to have passed
10 away when they were, let's say, 12, they never got SSI,
11 so it's this weird sort of glitch in the system and
12 people were not able to be Medicaid-eligible. So we've
13 created this kind of specialty category that we're
14 calling the non-DACS, again, affectionately referred to
15 as that here. Please don't write that up or distribute
16 it; it's not a technical term. But it will allow people
17 in this odd sort of situation to be able to become
18 Medicaid-eligible and get onto our Waiver Program. So,
19 again, we're happy about that.
20 And then the second eligibility category,
21 and this is a much smaller group -- all of these groups
22 are actually quite small, but this one is even smaller.
23 I think we only know of about 30 people in this group.
24 Might be a couple more, but it's relatively small. It's
25 individuals who meet the institutional financial

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1 eligibility level for Medicaid but wouldn't meet the
2 other clinical levels for Medicaid and, therefore,
3 couldn't get into The Supports Program. So we've
4 created, again, this very small sort of eligibility
5 carveout just for those folks.
6 So like I said, those amendments were all
7 submitted, along with some other technical amendments in
8 the summer and we're waiting to hear back. They have
9 until November and then we should be able to
10 operationalize from there.
11 I think that's all I have in terms of an
12 update. I think the primary thing to mention is that,
13 like I said, Cohort 2, we're identifying now, we're
14 working through what that group is going to look like. I
15 think it will be a little bit bigger than the first
16 cohort, but we still don't want to go too big until we
17 just make sure that we've got any of the glitches worked
18 out, because it's a massive amount of systems change and
19 we can't have providers not getting paid or people not
20 being able to access service. So some of it has to go a
21 little slower than we would like. But for the people in
22 the system, it's going quite well.
23 CHAIRWOMAN SPITALNIK: Thank you so much.
24 Questions from the MAAC?
25 MS. ROBERTS: Thank you very much, Liz.

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1 This was great information done very concisely and it's
2 helpful.
3 Can you comment at all on my question
4 earlier about the behavioral health.
5 MS. MIELKE: Your question was in general,
6 what are we doing about people with dual diagnosis?
7 MS. ROBERTS: Yes.
8 CHAIRWOMAN SPITALNIK: We use dual diagnosis
9 in two ways. In the mental health system, that typically
10 refers to people who have both mental health and
11 substance abuse needs. And in the developmental
12 disability (DD) system, the dual diagnosis is typically
13 people with developmental disabilities and mental health
14 needs. Co-occurring disorders covers a large number of
15 people.
16 MS. MIELKE: Thank you. I appreciate that.
17 As either Val or Bev mentioned earlier, one
18 of the issues we have in our current system or the way
19 our current system is set up, individuals with
20 developmental disabilities for their acute care health,
21 not on the long-term side, but just acute care health are
22 really the only group that are specifically carved into
23 managed care for their behavioral health needs, for their
24 mental health needs. So it operates as this sort of odd
25 thing, right, where we have one group of people just

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1 people with DDD. You could argue it's good or it's bad;
2 people have all different feelings about it. But it
3 operates as they kind of sit over here, and the entire
4 rest of the mental health system sort of sits over here.
5 So we've had conversations for years about what that
6 looks like and where it's going to go. I think that's
7 kind of the discussion now. I think a lot of it has to
8 do with the direction and the decisions that are being
9 made about the mental health system in general within the
10 State and Medicaid. We do have a meeting coming up to
11 talk about dual diagnosis and what the planning is. I
12 will tell you I think the thing that we do know is that
13 in preparation for the ASO, which has since been pulled,
14 but in preparation for that, a group of us, many of the
15 people in this room, had met regularly to talk about what
16 it needs to look like, what people with co-occurring
17 developmental disabilities and mental health issues, what
18 they need to support their health needs. And that
19 included people from the State, including myself, as well
20 as clinicians and people from the outside, advocates,
21 family members, et cetera. So I think the one very
22 positive thing we have is we do have a very
23 well-developed series of recommendations around what that
24 needs to look like. We got really into the weeds around
25 some areas. So when we have the meeting, which is coming

26

1 up in the next couple of weeks, I think that will
2 probably serve as the basis for us to figure out where do
3 we go from here and what does that need to look like.
4 But it's a little bit up in the air. I think what the
5 long-term plan is, it's a much larger issue. But there
6 is absolutely commitment at the departmental level to
7 figure out how to fill in some of those gaps, because
8 it's definitely an issue we're all aware of.
9 CHAIRWOMAN SPITALNIK: Others?
10 Anyone in the public?
11 MS. MIELKE: Thank you very much.
12 CHAIRWOMAN SPITALNIK: Thank you so much,
13 Liz and Valerie. I know you have other obligations.
14 Thank you so much for being with us.
15 I'm pleased now to welcome Nancy Day, the
16 Director of the Division of Aging Services (DoAS). Nancy
17 is going to update us about Managed Long Term Services
18 and Supports, Rebalancing, and the Balancing Incentive
19 Program (BIP).
20 I'd also like to remind people that the
21 PowerPoints that are shown are then available on the
22 Division of Medical Assistance website after the meeting
23 at: http://www.state.nj.us/humanservices/dmahs/boards/
24 maac/.
25 MS. DAY: Good morning. My task today is to

27

1 provide a very high-level update on what has transpired
2 for our Managed Long Term Services and Supports. And I
3 think it's important to look at it from two different
4 perspectives. One is to look at it from MLTSS, which
5 really is focussing on the individuals, moving people
6 from institutional settings into the home and
7 community-based setting. The second, which I'll talk
8 about under the BIP, the Balance Incentive Program, is
9 really looking at it from a financial perspective.
10 (Presentation by Ms. Day.)
11 (Slide presentations conducted at Medical
12 Assistance Advisory Council meetings are
13 available for viewing at http://www.state.nj.us
14 /humanservices/dmahs/boards/maac/)
15 CHAIRWOMAN SPITALNIK: Nancy, instead of
16 going on to the BIP, given the amount of information, I
17 think it would be good for us to have questions around
18 this data.
19 Yes, please.
20 MS. BRAND: Hi, Nancy. Two questions: With
21 respect to the duals, do you have a sense of what
22 percentage are enrolled in dual special needs plans
23 (D-SNP) plans at this time?
24 MS. DAY: I do not. I think they're not
25 counted in this. In MLTSS, they would not be counted.

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1 We'll have to verify that.
2 MS. BRAND: For our next meeting maybe.
3 MS. DAY: Yes.
4 MS. BRAND: Then, also, with respect to the
5 slide MLTSS population by setting, I'm assuming the bulk
6 of the services under home and community-based care are
7 the personal care assistant (PCA) services, but I'm
8 wondering is there what the top services are being
9 accessed at this time?
10 MS. DAY: Well, under the MLTSS, I think
11 you're right, in terms of percentage for home and
12 community-based would be primarily the personal care
13 attendants. We also have a lot of other people that are
14 enrolled in medical day care, and we have individuals
15 receiving transportation, non-medical transportation, the
16 PERS, which is the Personal Emergency Systems. We also
17 have a number of people enrolled in that. But I think
18 you're right, in terms of largest percentage of services
19 would be around personal care.
20 MS. BRAND: Would it be possible for a
21 future meeting just to break that out so we have a sense
22 of that?
23 MS. DAY: Absolutely.
24 MS. BRAND: Great. Thank you.
25 CHAIRWOMAN SPITALNIK: Anyone else?

1 MS. ROBERTS: My question has to do with the
2 age breakdown and the thinking that in all likelihood the
3 birth to 21 and then even some in the 21 to 35 are people
4 who were required to join MLTSS because they were
5 previously in the CRPD or the TBI waiver. And I don't
6 know if you can provide any additional information now or
7 for the next meeting. I don't want us to lose sight. I
8 know the numbers are relatively small, but they're a very
9 different group from the 65 and over and the people with
10 nursing home, et cetera. The CRPD folks were living with
11 their families or continuing to live with their families,
12 and so I just don't want to lose sight of some of their
13 challenges, particularly private duty nursing in the
14 previous on the CRPD waiver. So I don't know if you have
15 any information on that group or if you could provide it
16 next time.
17 MS. DAY: I think in terms of those 21 and
18 under, since that's, I think, more of your focus, again
19 the 35 to that 64, as you mentioned, for TBI, CRPD, those
20 services are still continuing. Those are ones that are
21 probably served mostly through what we refer to as our
22 interdisciplinary teams, looking at the range of
23 services. You mentioned private duty nursing. That
24 would be the heavy users of private duty nursing. The
25 plans of care are based on what those individuals need.

1 So I'll be happy in terms of our next presentation to
2 focus more on the services that they provide, as opposed
3 to the numbers. But their care needs are being met
4 appropriately based on their assessments, their plan of
5 care. I think we're still addressing the same kind of
6 level of services that they had previously. So it sounds
7 like more than just the numbers. Maybe next time we'll
8 focus on some of the services from that perspective.
9 MS. ROBERTS: Also, I don't know if you have
10 complaint and grievance data from that group
11 specifically. Because I hear anecdotally when there's a
12 problem, and other people who are attorneys may hear
13 about problems. That doesn't mean we're getting the full
14 picture, but I don't know if you have data on that.
15 MS. DAY: In terms of grievances, I think
16 we'll have to pull that data together. I don't have it
17 here. I know that we track those. I think what we'll
18 have to do is look at the types of categories of
19 grievances. I think for all of us, when it comes to our
20 desk, it sounds like there are major problems; and
21 sometimes it may be a smaller number of people but they
22 represent significant problems that we want to address.
23 MS. ROBERTS: Thank you.
24 CHAIRWOMAN SPITALNIK: Thank you.
25 Raquel.

1 MS. JEFFERS: Hi. Raquel Jeffers, Nicholson
2 Foundation.
3 MLTSS has behavioral health services carved
4 in, so I was wondering maybe when you dig a little bit
5 deeper into looking at the service profile if you could
6 also share how those services are going for that
7 population and what services they're actually accessing
8 and are people able to get their behavioral health needs
9 met through MLTSS.
10 MS. DAY: Again, sounds like those are the
11 issues that you'd like more information about, the
12 services, the types of people, the network. I think for
13 us, under MLTSS, since it was the first time of having a
14 carve-in for mental health is the fact that we are also
15 building at the same time the capacity in the community.
16 So it's a lot of challenges to start up a new support
17 program that was previously not a part of our world.
18 We do have from our regular conference calls
19 with the managed care organizations (MCOs), they're
20 always including their behavioral health administrators
21 on the call, so we are trying to be very proactive in
22 that area and be much more aware of some of the rising
23 issues and how we can address them.
24 CHAIRWOMAN SPITALNIK: Thank you.
25 Please go on with the next update around the

1 rebalancing data.
2 MS. DAY: Okay. The New Jersey BIP, as I
3 mentioned, it stands for Balance Incentive Program.
4 (Presentation by Ms. Day)
5 (Slide presentations conducted at Medical
6 Assistance Advisory Council meetings are
7 available for viewing at http://www.state.nj.us
8 /humanservices/dmahs/boards/maac/)
9 MS. DAY: Any questions on the BIP?
10 CHAIRWOMAN SPITALNIK: Gwen Orlowski.
11 MS. ORLOWSKI: Gwen Orlowski, Central Jersey
12 Legal Services. I have a question about the last
13 presentation.
14 I would be interested also when you do some
15 more information about what sort of health services are
16 being used and how people are accessing MLTSS to get
17 information about people who are using Qualified Income
18 Trusts (QITs).
19 One of things that we're hearing at Legal
20 Services, and I think that may be true of other legal
21 services providers for low income people, is we really
22 don't provide direct representation for QITs. Those
23 people are too high for our income eligibility
24 requirements. I'm just curious how people are doing, if
25 it's working, is what's on the website effective?

1 For the future, we need to think about how
2 we can assist those people, given the way legal services
3 is delivered in the State of New Jersey. Thank you.
4 CHAIRWOMAN SPITALNIK: Thank you for that.
5 Any other questions?
6 Nancy, thank you so much. And at the end
7 when we recap the issues that have been raised for the
8 next agenda, I'll try to recount the data requests that
9 were made about MLTSS and the BIP.
10 It's now my pleasure to welcome back Dr.
11 Thomas Lind, who is the Medical Director at NJ
12 FamilyCare, to talk about Provider Credentialing.
13 Dr. Lind.
14 DR. LIND: Good morning. I'm just going to
15 remind you, as you may recall, Molina Medicaid Solutions
16 was awarded the replacement MMIS contract in May, and I
17 just wanted to provide you with some updates on where we
18 are today with a new credentialing system.
19 It's a very exciting time. We're making the
20 transition quickly from theory into practice, and we are
21 now in full boot-camp mode. We're very aggressively
22 scheduling day-long meetings several times a week, which
23 is a creating log-jams, but it's been tremendously
24 stimulating.
25 We're meeting with our contractor and we're

1 trying to design a credentialing system that will gather
2 and process the vast amounts of data that we need to for
3 credentialing and verification, while remaining user
4 friendly. We're in the process of trying to automate the
5 portals, the MCO and the provider portals, so that the
6 information that we gather will be accessible. We are
7 looking to have a live demo in April of 2016, and we are
8 currently still on time for July 2016 implementation
9 timeframe.
10 CHAIRWOMAN SPITALNIK: Thank you.
11 Questions?
12 With thanks and appreciation of how much has
13 been accomplished.
14 DR. LIND: Thank you.
15 CHAIRWOMAN SPITALNIK: Let's turn to
16 Director Valerie Harr who has a series of updates to
17 report on. And we'll take time at the end of each chunk
18 to see if there are questions.
19 Director Harr.
20 MS. HARR: Good morning, everybody. Most of
21 these topics are items that were requested at the last
22 Medical Assistance Advisory Council (MAAC) meeting. I
23 think some were at the request of MAAC members that may
24 not be here today. But if I'm not responding to
25 questions that you recall and we need to get back with

1 additional information, just let me know. Again, I think
2 we're trying to be responsive to the last meeting.
3 So a standing agenda item that we've had is
4 just an update on NJ FamilyCare, particularly around the
5 figures related to the Expansion.
6 (Presentation by Ms. Harr)
7 (Slide presentations conducted at Medical
8 Assistance Advisory Council meetings are
9 available for viewing at http://www.state.nj.us
10 /humanservices/dmahs/boards/maac/)
11 MS. HARR: I think that was it for the
12 slides; but, at the last meeting, someone had asked about
13 what we are doing to have a seamless transition from the
14 health benefits coordinator (HBC) to the county welfare
15 agency (CWA) or vice versa. So a couple things we've
16 done is we sent out a Medicaid Communication (MedComm) to
17 all of our statewide eligibility determination agencies
18 in April reinforcing the policy to asses NJ FamilyCare
19 beneficiaries for other Medicaid programs prior to
20 termination. So it's just a reinforcement of the policy
21 to both our health benefits coordinator and county
22 welfare agencies that before you terminate somebody for
23 Medicaid eligibility, they must be screened to see if
24 they are eligible for other programs.
25 And if someone is screened through the

1 health benefits coordinator or county welfare agency and
2 they are over income for Medicaid or NJ FamilyCare, they
3 are referred to the Federal Marketplace, in writing.
4 I think that covers the expansion enrollment
5 update.
6 CHAIRWOMAN SPITALNIK: Thank you. I think
7 this would be a good point to ask for questions. Are
8 there any from the MAAC around Expansion and Enrollment?
9 Any from the public?
10 Ray and then Gwen and then Maura.
11 MR. CASTRO: Ray Castro, New Jersey Policy
12 Perspective.
13 As you indicated, enrollment has leveled
14 off, and it's pretty clear that people who have been
15 motivated to apply have already done so. So the folks
16 who are remaining are the most difficult to reach and
17 have many, many barriers. And I'm just wondering, have
18 you thought about a strategy to reach all of those folks?
19 We have to do an even more intensive effort to reach
20 those individuals who probably are even more vulnerable
21 than the folks who have enrolled already.
22 MS. HARR: It has been just a re-current
23 problem with NJ FamilyCare and kids, the last remaining,
24 the most difficult to reach. So we haven't taken on any
25 new initiatives. I think the thing that concerns me more

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1 is what we're seeing around redeterminations. And there
2 are a large number -- at least those that we have seen
3 that originally applied at The Marketplace and became NJ
4 FamilyCare enrolled, they are not responding to the
5 renewal. They are given three reminders, the first one,
6 75 days in advance. We have asked the HBC to call. And
7 individuals say, "Well, I just didn't get around to it.
8 I will" and then they're not.
9 So I think we're going to see a pretty
10 significant number of people that are going to lose their
11 eligibility for non-response. So we've been talking
12 internally because at some point they will get a tax
13 penalty. I don't know how to change that. I've talked
14 to CMS about it, too, to see if they're seeing this in
15 other states. I didn't get an indication that they have.
16 So, yes. Not only do we need to -- what are
17 we going to do to get the most difficult to reach, what
18 are we going to do to actually get people that were
19 eligible and probably still are eligible to remain
20 eligible.
21 CHAIRWOMAN SPITALNIK: Thank you.
22 Gwen.
23 MS. ORLOWSKI: Gwen Orlowski, Central Jersey
24 Legal Services.
25 Thank you again for the presentation. It's

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1 really, really helpful.
2 You mentioned the Medicaid communication
3 from April reminding that folks who are being terminated
4 from NJ FamilyCare need to be screened for other Medicaid
5 eligibility, and we really do appreciate that.
6 I would like to put a little bit of focus on
7 the group of people who are transitioning to Medicare,
8 because that's the highest. Many people know I've been
9 back since May, and that is a real spike that I see,
10 people who were on Expansion Medicaid and now became
11 eligible for Medicare. And there are really unique
12 problems that go around that transition and identifying
13 those folks earlier in the process so that they can begin
14 the transition application, and not only for Aged, Blind
15 or Disabled (ABD) or for MLTSS, but really thinking
16 through how New Jersey is doing their special Medicare
17 programs for the Part B Eligibility. Giving people a
18 packet that they have to apply when they present
19 themselves at the Board of Social Services and saying,
20 "Here's your packet, you've got to go up and do something
21 else" is really not in accordance with the federal law.
22 Those folks should be able to be screened for that Part B
23 eligibility prior to termination.
24 Now, I do want to emphasize again that these
25 are people who really are living on very low income, and

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1 losing that $104.90 is significant in their lives and can
2 mean the difference between paying the rent, and not
3 paying the rent.
4 MS. HARR: Thank you. And definitely, Gwen,
5 I would take any suggestions you have. I mean, one of
6 the things that we do know is we do see individuals in
7 the Expansion population that are turning 65 and they are
8 no longer eligible for the Expansion, and we talked to
9 Legal Services about this. And we're looking to see if
10 we can identify individuals in advance that would be
11 turning 65 and get a communication, to get a letter out
12 to those individuals to do something proactive so that
13 they have enough time to make plans for other programs.
14 So that's one thing.
15 We would like things to be a lot more
16 seamless. We are looking to make some upgrades to our NJ
17 FamilyCare administrative tool that is the tool that sits
18 behind that NJ FamilyCare application. It's where the
19 county welfare agencies and the HBC pull down the
20 application to process to see if there's a way that we
21 can have more data in there so that the applications can
22 be viewed and transitioned between the HBC and the county
23 welfare agencies who are ready to make things like this
24 smoother so someone is not just handed a packet. What
25 can we do to see if the folks at PAAD are able to maybe

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1 to access that information in more real time?
2 So Nancy Day said they've already started to
3 look at that and working with our Eligibility staff.
4 MS. ORLOWSKI: Can I say one quick follow-up
5 to that? I do know that this is was an issue down in
6 Washington that gathered a lot of attention because it's
7 a problem everywhere in the country. The Center for
8 Medicare Advocacy and Medicare Right Center really have
9 looked at this issue. So it might be worthwhile -- and I
10 can reach out to them to see if there are some models for
11 how to do this more seamlessly.
12 MS. HARR: Thank you. I would definite
13 appreciate that. Thank you.
14 CHAIRWOMAN SPITALNIK: Thank you.
15 Maura.
16 MS. COLLINSGRO: Maura Collinsgro with New
17 Jersey Citizen Action.
18 The 80 percent of the applications are being
19 processed by the HBC within the 45 days. Can you give us
20 an update on the other applications, our famous flat file
21 transfers and the county welfare agencies? I know that
22 you had requested that they report to the Department, and
23 what the status is with that, as well as the update on
24 the information technology (IT) system contract, if
25 there's any updates on that.

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1 And just very briefly on The Marketplace
2 notification when people are sent a letter, we did
3 actually request this, CMS said that they were going to
4 reach out on this. It does say that you can apply to The
5 Marketplace in that a letter. It does not tell people
6 they only have 60 days. So we're asking for the letter
7 that comes from NJ FamilyCare to put into that statement,
8 which is at the end of the letter, that they have just 60
9 days to do that.
10 MS. HARR: Yes, we're making that change.
11 So we are no longer processing flat files
12 because we have account transfers, so we are receiving
13 real time account transfers from The Marketplace to the
14 State to enroll individuals that apply through The
15 Marketplace that are NJ FamilyCare eligible. So that's a
16 piece of good news.
17 The county welfare agencies do continue to
18 report their backlog to us now on a monthly basis. They
19 have just several hundred backlogged applications
20 statewide. So essentially, we have little to no backlog
21 of applications at the county welfare agencies. And
22 that's for all for NJ FamilyCare.
23 We have not yet developed the long-term plan
24 for new eligibility enrollment system. I think that's
25 what you were asking about. So as soon as I would have

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1 additional information, I would share that with you, but
2 there's no news on that front right now.
3 Like I mentioned before, we're continuing to
4 rely on the NJ FamilyCare website and that platform, and
5 it's supported by a vendor called SalesForce, so we're
6 continuing to utilize that. Again, we were able to do
7 account transfers received. In the next month we will be
8 sending, so when somebody is determined no longer
9 eligible for NJ FamilyCare for being over income, we will
10 be doing account transfers to send that to The
11 Marketplace in the coming months.
12 So there are a lot of upgrades and
13 improvements. I think I mentioned before we're working
14 on an online application, so we continue to make progress
15 as we determine what the longer-term solution is for an
16 Integrated Eligibility System.
17 UNIDENTIFIED SPEAKER: Can I just ask a
18 follow-up, Valerie?
19 On the consultant study that we were
20 awaiting in May, what could be salvaged from the previous
21 contract? Has that study been issued yet?
22 MS. HARR: It has not been issued. It has
23 been finalized and shared with our CMS partners, but the
24 Director of the Division and Family Development and I
25 will be having a discussion with our federal partners to

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1 review that report.
2 CHAIRWOMAN SPITALNIK: Other questions?
3 MS. ROBERTS: A follow-up comment on what
4 Gwen had said about age 65, people with Expansion, they
5 turn 65 and they get Medicare. There are people with
6 disabilities of any age, some of them are my population,
7 but they could be anybody who is getting SSD because of a
8 disability. And then 24 months after the SSD, they get
9 Medicare. So that would be another group of people
10 potentially in Medicaid Expansion and they're going to
11 get knocked out, but they're not 65.
12 MS. HARR: We have those on our radar.
13 CHAIRWOMAN SPITALNIK: Thank you.
14 So we'll turn to you for information on
15 appeals and grievances.
16 MS. HARR: It's my understanding that a
17 chart on appeals and grievances was shared with the MAAC.
18 So just to remind everybody, the requirement is that if
19 an individual -- our contract says that concerning
20 members rights to appeal for Managed Long Term Services
21 and Supports, medical service, dental, mental health and
22 substance abuse decisions, the procedure is that the
23 enrollee who is receiving a service prior to the
24 determination, the contractor -- in this case it's our
25 MCOs -- must continue to provide the same level of

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1 service while a determination is in appeal. So again,
2 we're talking a service reduction or denial. Services
3 must remain while the appeal is being determined.
4 The member can also request a Medicaid fair
5 hearing within 20 days of the date of that MCO Notice of
6 Action letter.
7 Also, for those individuals who requested a
8 Medicaid fair hearing process, continuation of benefits
9 must be requested in writing within 20 days of the date
10 of the denial letter.
11 So again, it's a little bit confusing. So
12 if an individual has appealed at the MCO and is awaiting
13 a determination, services would be continued at the level
14 that they had been while the appeal is being determined.
15 For the Medicaid fair hearing, you must request that your
16 benefits be continued. So there is a little bit of a
17 distinction there.
18 For MCO appeals, there are three levels of
19 appeal. Level 1 appeal, the appeal process shall consist
20 of an informal internal review by the contractor. Member
21 has 90 days to appeal from the time the denial letter was
22 received.
23 Level 2, the formal internal review is by
24 the contractor, the MCO. The member has 90 days to file
25 an appeal from the time the denial letter was received.

1 And then Level 3 appeal is a formal external
2 review by an independent utilization review organization
3 under a Department of Banking and Insurance (DOBI) and/or
4 the Medicaid fair hearing process. The stage 3 external
5 appeal process, as I mentioned, is administered by
6 Department of Banking and Insurance and is utilized for
7 the review of appropriate utilization and medical
8 necessity.
9 So there are some services, though, that
10 would not be heard by the Department of Banking and
11 Insurance Internal Review Committee. And those services
12 that are not eligible for those Stage 3 DOBI appeal
13 process are adult NJ FamilyCare, assisted living, program
14 assisted living services, caregiver participant training,
15 chore services, community transition services, home-based
16 supportive care, home delivered meals, personal care
17 attendant services, respite, social day care, structured
18 day program, and supported day services when the denial
19 is not based on the diagnosis of a traumatic brain
20 injury. So again, these are services that would not
21 qualify for a Stage 3 appeal with the Department of
22 Banking and Insurance.
23 So that was to refresh individuals on the
24 appeal process. I can take questions on that.
25 CHAIRWOMAN SPITALNIK: Questions from the

1 MAAC?
2 From the public?
3 Please give us your name when you ask your
4 questions.
5 MS. ALLEN: My name is Lolita, and I'm a
6 parent of a child. I went through the appeal process,
7 and I was sent a letter stating that I can apply to the
8 Appellate.
9 CHAIRWOMAN SPITALNIK: I'm sorry, we can't
10 hear you up here.
11 MS. ALLEN: I went through all the state. I
12 was given a letter stating that I can file with the
13 Appellate Division. So my question was from originally
14 when you said the services must continue, once it's
15 denied at the third level and I'm appealing at the
16 Appellate Division, are they still allowed to cut my
17 services if I'm still appealing?
18 MS. HARR: Maybe we could follow-up after
19 and I can get your information. But based on what you're
20 telling me, you're saying you're now at the Appellate
21 Division. It sounds to me like maybe you went through
22 the fair hearing process. And if the fair hearing
23 decision did not support your request, then your next
24 level is to go to the Appellate Division. That's what
25 I'm guessing based on what I'm hearing. But if you want

1 to give me your contact when we're done, we can
2 definitely follow-up with you on the specifics.
3 So if you filed for a fair hearing and asked
4 for continuation of benefits, that would have continued
5 through the fair hearing process but not after the fair
6 hearing. If you had appealed through the MCO, the
7 services would continue through the MCO appeal process,
8 as well. I would say it sounds like you went through the
9 fair hearing process, and the services wouldn't continue
10 after that.
11 MS. ALLEN: What about an External Review?
12 MS. HARR: If it's after the External
13 Review, it would depend on the decision. We'll figure
14 out where the appeal is in the process and work with you.
15 MS. ALLEN: Thank you.
16 CHAIRWOMAN SPITALNIK: Thank you.
17 Other questions?
18 Thank you.
19 Valerie, the managed care contract changes,
20 please.
21 MS. HARR: The contract changes for July are
22 with CMS for approval. So once the contract is approved
23 by CMS, if we have to either make changes or any
24 corrections, once it's finalized by CMS, it will be
25 posted to our website.

1 MS. ROBERTS: When is that expected?
2 MS. HARR: I can't speak for CMS.
3 MS. ROBERTS: Roughly?
4 MS. HARR: We are unable to determine that.
5 CHAIRWOMAN SPITALNIK: Thank you.
6 Gwen.
7 MS. ORLOWSKI: Gwen Orlowski, Central Jersey
8 Legal Services. Thank you. I know that the contract
9 that's online right now is from January.
10 One of the things that as an advocate would
11 matter in this is that the new contract contains the new
12 numbers for capitated rates so we're really looking
13 forward to seeing that. But we would also really ask
14 that the annual threshold numbers would be transparent.
15 There's been a lot of concern about that those are in
16 some ways not transparent or not proprietary for some
17 reason. And yet when folks go to fair hearings, of
18 course, that number is essential to determine whether or
19 not your budget really is within a certain percentage.
20 We do have those numbers, by the way, from State Fiscal
21 Year '15 because they were received through litigation.
22 But since they can be received through litigation, it
23 just seems to make sense to me to post those on the
24 website, as well. Thanks.
25

MS. HARR: Nancy, can I ask you to comment?
MS. DAY: Those numbers are fair to individuals as to where they fall. Are we saying that we do not have the updated numbers?
MS. ORLOWSKI: It's a chart for the State Fiscal Year 2015 that we advocates have because a particular attorney litigated and got that as part of discovery. It would be great if that chart could also be online. You get capitated numbers with the new contract, but this is just a little bit different.
MS. DAY: That will be fine. We'll make sure to review your request.
CHAIRWOMAN SPITALNIK: Thank you.
Maura.
MS. COLLINSGRO: Maura Collinsgro, Citizens in Action. I just had a question about the appeals and the grievances. Do you have any stats on the number of appeals and the disposition of those appeals?
MS. HARR: Yes. That data was provided to the MAAC Members only.
CHAIRWOMAN SPITALNIK: Thank you.
Any other questions?
The Federal Managed Care New Proposed Rulemaking.
MS. HARR: Again, they're proposed

regulations. We did not submit formal comments, but we worked with our various associations, i.e., the National Association Medicaid Directors. We know he had a conversation. Theresa, I think, was on vacation. And definitely her association and their comments definitely reflected those that we had been concerned about. So I don't think we have any additional information on those regulations at this time.
CHAIRWOMAN SPITALNIK: Thank you.
Transportation Request for Proposal.
MS. HARR: Soon. It is still pending. We're in communication with the Division of Purchase and Property almost daily checking on this. The contract does is not expire, I think, for another year, so Purchase and Property, as they weigh their priorities, because there is another year extension, they may not see the urgency that we do. But we continue to request that that RFP get posted as soon as possible.
MS. EDELSTEIN: Is there anything that we can do to express our urgency concerning that RFP?
MS. HARR: I know there are other organizations that have contacted Purchase and Property directly. I think you're welcome to do that, but it hasn't changed the outcome.
MS. EDELSTEIN: I was thinking about the

MAAC more than an individual.
MS. HARR: You may want to consider that.
CHAIRWOMAN SPITALNIK: If we want to consider that, at this point we can convey a sense of the MAAC if that's people's pleasure. We don't have a quorum, so we can't really formally take any action. Why don't we put that on the agenda for January. And if soon hasn't arrived, we can take that in up in terms of expressing the concern of the MAAC. Thank you.
Accountable Care Organizations.
MS. HARR: Since our last meeting, we did certify three Accountable Care Organizations (ACOs), Camden Coalition of Health Care Providers, Healthy Greater Newark ACO, and Trenton Health Team. We've met with all three. Incredibly wonderful meetings. Productive. They are collaborating with one another, working with the Health Care Quality Institute on things that are cross-cutting. And we're working to sign three business associate agreements with the ACOs so that we can exchange or provide data to them on the members that they are responsible for in their catchment area.
There are the other ACOs that were not certified. Certainly, we have a tremendous amount of respect for them as they continue to try to address the unique factors in their community and assess the needs of

their community. So we've met with some of those, as well. I want to make sure that we continue to work with them as they try to develop their model. So just because they weren't certified doesn't mean that they're not doing incredible work, and we want to support that so that we can support the Medicaid members in their community.
I was thinking that it may be nice in the future MAACs to have the ACOs come in and do their own presentations to let you know what's going on, what their target efforts are, if that would be of interest instead of just hearing it secondhand from me.
CHAIRWOMAN SPITALNIK: Thank you.
MS. BRAND: I just wanted to, in transparency, share that I am a member of the Healthy Greater Newark Medicaid ACO Board. So if the MAAC were to have to vote on something, I would recuse myself from it. I wouldn't leave the room because it's a public meeting, but I certainly would recuse myself.
CHAIRWOMAN SPITALNIK: Thank you very much for that clarification.
Anything else from the MAAC?
Yes?
MS. ALLEN: I just had a quick question. What is the Accountable Care?

1 MS. HARR: The Accountable Care
2 Organization, there was a statute, there was law passed
3 in 2011 that called for the Medicaid agency to develop a
4 demonstration to certify a non-profit organization that
5 had broad representation in a board within their
6 community that would serve at least 5,000 Medicaid
7 members. And really, I would say if I had to boil it
8 down, it's taking the most challenging Medicaid
9 population that have frequent inpatient hospitalizations,
10 lots of other social challenges in their lives, not just
11 medical, very complex populations, and providing
12 intensive case management. It's bedside. It's going to
13 the hospital, so there are a team of social workers,
14 nurses, that are part of these Accountable Care
15 Organizations that are going, like I said, bedside and
16 working to address a complex set of factors to improve
17 someone's overall quality of life and their health care
18 and really try to reduce their emergency room visits or
19 inpatient hospital stays. And then the premises is that
20 the new sort of model that's emerging in the country is
21 that if this group of providers are able to demonstrate
22 that they've saved money through their interventions,
23 they share in the savings so it becomes a gain-sharing
24 plan.
25 So it's a new model of delivering care to

1 the most vulnerable Medicaid population, if I had to boil
2 it down. But it was a statute, followed by regulation,
3 and then these three communities have demonstrated that
4 they meet the terms of the law implementing their
5 program.
6 MS. ALLEN: So are these organizations, are
7 they insurance companies, providers?
8 MS. HARR: The ACO is a not-for-profit
9 organization represented with a board of -- it's mostly
10 provider and community-based organizations that are
11 members of the Accountable Care Organization. The ACO
12 itself is a not-for-profit.
13 CHAIRWOMAN SPITALNIK: Thank you.
14 Other questions or comments?
15 Thank you very much.
16 I had moved the reading of the Senate
17 resolution that had been introduced by Senator Weinberg.
18 I have a visual, which I'll pass around, of the signing.
19 It recognizes many of the people in this room. This is a
20 resolution, New Jersey State Senate Resolution. It was
21 passed on August 26th.
22 "Whereas, the Senate of the State of New
23 Jersey is pleased to note the occasion of the 50th
24 anniversary of the enactment of the Social Security
25 Amendments of 1965 that created Medicare and Medicaid,

1 thus, transforming our nation's health care systems and
2 improving the quality of life of millions of Americans;
3 and
4 "Whereas, on July 30, 1965, President Lyndon
5 Johnson's Title 18 and Title 19 of the Social Security
6 Act into law at the Harry S. Truman Library in
7 Independence, Missouri, establishing Medicare and
8 Medicaid; and
9 "Whereas, the creation of Medicare and
10 Medicaid has paved the way for several other landmark
11 initiatives, such as the Medicare Prescription Drug
12 Improvement and Modernization Act, the Children's Health
13 Insurance Program, and the Affordable Care Act; and
14 "Whereas, the Garden State currently has 1.3
15 million Medicare beneficiaries, and nearly one out of
16 every five residents are enrolled in Medicaid, making
17 this State the recipient of the tenth largest amount of
18 federal Medicaid funding in the country; and
19 "Whereas, since their formation, Medicare
20 and Medicaid have significantly enhanced the lives of
21 individuals throughout the United States, including low
22 income families, pregnant women, people with
23 disabilities, and those in need of long-term care; and
24 "Whereas, the strength and success of the
25 State of New Jersey, the vitality of our communities, and

1 the effectiveness of our American society depend in great
2 measure upon concerned and dedicated social service
3 programs such as Medicare and Medicaid; and
4 "Whereas, it is both fitting and proper that
5 the New Jersey Senate to acknowledge the 50th anniversary
6 of the enactment of Medicare and Medicaid; now,
7 therefore,
8 "Be it resolved by the Senate of the State
9 of New Jersey that this House hereby takes notes of the
10 50 anniversary of Medicare and Medicaid and pays tribute
11 to the meritorious record of service and commitment of
12 these essential programs that have spanned a half
13 century; and
14 "Be it resolved that a duly authenticated
15 copy of this resolution be signed by the President of the
16 Senate and attested by the Secretary."
17 So in celebration and with thanks to the
18 advocacy community, which really recognizes the dedicated
19 the work, the importance of Medicaid, and shall we also
20 add the incredible dedication of the staff of the
21 Division of Medical Assistance and Health Services.
22 (Applause.)
23 CHAIRWOMAN SPITALNIK: So on that high note,
24 let me review what I've captured of what we had been
25 interested in including in our next meeting's agenda.

1 And I will read the dates of our next meeting.
2 At your suggestion, Valerie, perhaps an ACO
3 presentation.
4 We would like to revisit the issue of the
5 transportation RFP and convey the sense of the importance
6 of this to the MAAC.
7 We would, as we have previously, have an
8 update on eligibility and numbers served.
9 There were also points that were raised
10 about diving deeper into more data, particularly in terms
11 of MLTSS and Behavioral Health and the types of services
12 that are being requested and utilized.
13 And there was also a request for information
14 on qualified income trusts.
15 Further data looking at tracking grievances
16 and more in depth in terms of data on the Duals and the
17 DSNPs plan as well as the top services being utilized in
18 MLTSS.
19 I think that's all I captured.
20 Are there other things that I missed or that
21 people would like to add to that?
22 Beverly.
23 MS. ROBERTS: The future behavioral health
24 services, including my personal interest, which is folks
25 with a dual diagnosis, but broadly, I think people would

1 like to know about behavioral health services outside of
2 MLTSS.
3 CHAIRWOMAN SPITALNIK: And we're talking
4 about individuals with development disabilities and
5 co-occurring disorders?
6 MS. ROBERTS: Correct. And also MCO
7 contract changes, which apparently are going to be
8 available soon. We would love to know what they are.
9 CHAIRWOMAN SPITALNIK: Anything else?
10 Gwen.
11 MS. ORLOWSKI: I just want to emphasize
12 again, I think some of us were a little bit confused. We
13 thought we were going to see some of the appeal grievance
14 and fair hearing numbers today. In particular, at the
15 last MAAC meeting, I asked for the first six months of
16 MLTSS, from July of 2014 through December, so it would be
17 great if we could have that. It's hard to ask questions
18 if we don't see that data. Thank you.
19 MS. HARR: The MLTSS, I think that Mary Beth
20 is working on that. We didn't have that available, but
21 she's working on that.
22 MS. ORLOWSKI: Thank you.
23 CHAIRWOMAN SPITALNIK: So MLTSS appeals and
24 grievances data and to have it visually accessible.
25 MS. ORLOWSKI: Thank you.

1 CHAIRWOMAN SPITALNIK: Kevin.
2 MR. CASEY: Kevin Casey, New Jersey Council
3 on Developmental Disabilities.
4 I just want to support Beverly's call for a
5 much more extensive discussion of supports for folks with
6 developmental disabilities.
7 Second, I'd really like us to look at the
8 confusion of this system to families and consumers. I've
9 talked to more and more families who do not understand
10 the appeals and grievance structure, how to get through
11 it, how to work it, and how to get some personal help for
12 those families.
13 We could also consider the same thing on
14 eligibility, by the way, where we're not able to get
15 through people we know are eligible, shouldn't we be
16 sending a human being out to talk to those folks at some
17 point in the process? So some overall discussion about
18 the confusion of the system to families and consumers.
19 CHAIRWOMAN SPITALNIK: Yes.
20 MS. ALLEN: I'm Lolita Allen. I'm a family
21 member. Based on what the gentleman just said, there are
22 many people who understand the process, they don't agree
23 with the process. They're putting our children in boxes.
24 And they're not looking at each individual situation.
25 I think that the people that are making

1 these rules are the ones who don't have children with
2 disabilities and they don't know what it takes to care
3 for a child with disabilities. I'm also a nurse and a
4 case manager, so I understand it on many levels. And now
5 I'm unemployed because of some of the decisions that are
6 being made to put our children in those boxes. So that's
7 why I'm here. So that I can learn and communicate with
8 this staff, whomever it is, that drastic changes need to
9 be made because people are losing their homes, they're
10 losing their jobs, they're forced to move to a different
11 state so that they can get the care for their child. And
12 it's really not cost effective or it's not benefiting a
13 lot of people, particularly the child.
14 CHAIRWOMAN SPITALNIK: Thank you. I'm
15 taking agenda items now.
16 Ray, did you have an agenda item for next
17 time?
18 MR. CASTRO: Ray Castro, New Jersey Policy
19 perspective.
20 I'm wondering if the Division can do a kind
21 of demographic analysis of the Medicaid Expansion. We
22 have huge number of new categories, near elderly, working
23 young single folks, and some on. I'm wondering if that
24 could be explained and also the types of services that
25 they are utilizing. We're seeing that this group has

1 greatly changed the profile of our usual Medicaid
2 recipient, and it would be helpful to have a handle on
3 that.
4 MS. HARR: We could break down the
5 demographics. I don't know how much more detail you
6 want, because I gave the spending. You're going see it's
7 inpatient, it's outpatient, physician services, pharmacy,
8 dental. That's in terms of the Expansion. I don't know
9 if you want a level deeper than that in terms of the
10 utilization.
11 MR. CASTRO: Well, more the type of
12 individuals that we are now seeing in terms like an age
13 breakout.
14 MS. HARR: Yes, we can do that.
15 MR. CASTRO: If you can break it out
16 racially and ethically, geographical location, how many
17 are wage earners, how many are not wage earners, how many
18 are college students, for example, are college graduates?
19 Whatever information you have. I know that's a lot, but
20 whatever information you do have, because right now we
21 don't have any information except the spending numbers.
22 CHAIRWOMAN SPITALNIK: Okay.
23 Gwen.
24 MS. ORLOWSKI: Hi. I promise this is the
25 last comment.

1 CHAIRWOMAN SPITALNIK: I'm really taking
2 agenda items.
3 MS. ORLOWSKI: It is an agenda item. But
4 it's following-up on some of the things that were said.
5 And maybe not for the next meeting, but prospectively as
6 we're coming up on doing a renewal for 2017, there's a
7 theme about access to advocacy for members. And when New
8 Jersey did our Comprehensive Waiver, we were on the front
9 end of things, so CMS's what was a recommendation but I
10 think in the new rules it's going to be a requirements,
11 I'm going to call it an ombudsman function, but I think
12 even CMS is moving away an advocacy role, whether it's an
13 ombudsman or a legal services or some other way of
14 envisioning that to think about how people really get
15 advocacy throughout the spectrum of accessing care, not
16 just at fair hearing stage, but eligibility, accessing
17 the services, care management functions, and beyond. And
18 I think that really is embodied in the CMS's vision. And
19 because we were so early here in New Jersey, we don't
20 have it. But sort of planning for the future on that,
21 not necessarily in January, but maybe next spring.
22 CHAIRWOMAN SPITALNIK: Thank you very much.
23 Any new business?
24 Before we adjourn, I want to announce the
25 dates of our next meetings. These are also posted on the

1 website at http://www.state.nj.us/humanservices/
2 dmahs/boards/maac/.
3 We will meet in 2016 on Wednesday, January
4 20th; Wednesday, April 20th; Wednesday, June 15th; and
5 then a year from today, Wednesday, October 19th. Our
6 meetings are 10 a.m. to 1 p.m., and they will continue to
7 be held here at this location.
8 Apologies for any of the delays in entry and
9 identification. Thank you all. A good Thanksgiving to
10 everyone; although, it's a little early to say that.
11 We are adjourned and I look forward to
12 seeing you on January 20, 2016. Thank you all for your
13 participation.
14 (Proceeding adjourned at 12:01 p.m.)
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