MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING
NJ Forensic Science Technology Center
1200 Negron Drive
Hamilton, New Jersey

April 8, 2013
10:00 a.m.

FINAL MEETING SUMMARY

PANEL:

DR. DEBORAH SPITALNIK, PH.D.
MARY COOGAN
EILEEN COYNE
THERESA EDELSTEIN
DENNIS LAFER
DOROTHEA LIBMAN
BEVERLY ROBERTS
DR. SIDNEY WHITMAN
WAYNE VIVIAN

STATE REPRESENTATIVE:
VALERIE HARR, Director
Division of Medical Assistance and Health Services

Transcriber, Lisa C. Bradley
THE SCRIBE
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
thelscribe@gmail.com

ATTENDEES:

Evelyn Liebman	AARP
Michael Rooney	Alkermes, Inc.
Dan Keating	Alliance for the Betterment of Citizens with Disabilities
Jennifer Jacobs	Amerigroup New Jersey, Inc.
Cathy Chin	Alman Group, LLC
Eric Uderitz	Boehringer Ingelheim
Barbara Geiger-Parker	Brain Injury Assoc. of NJ
Lisa Knowles	Care Point Health Plans
John Guhl	Centers for Medicare and Medicaid Services
Doretha Howard	Centers for Medicare and Medicaid Services
Nicole McKnight	Centers for Medicare and Medicaid Services
Mary Katherine Bohan	Community Care Behavioral Health
Sue Saidel	Essex Court
Andrea Cotton	Healthfirst Plan of NJ
Karen Clark	Horizon NJ Health
Len Kudgis	Horizon NJ Health
Joseph Manger	Horizon NJ Health
Phil Lachaga	Johnson and Johnson
Michelle Paulik	Johnson and Johnson
Carol Katz	Katz Government Affairs
Eric Orlando	Kaufman Zita
Josh Spielberg	Legal Services of New Jersey
Andrew Robertson	Legislative Liaison
Sabeen Kaylan-Masih	Legislative Liaison
Christine Walley	LIFE St. Francis
Colleen Smith	Matheny Medical & Educational Center
Barbara Johnston	Mental Health Association in New Jersey
Michele Jaker	MJ Strategies, LLC
Carolyn Bray	New Jersey Association of Mental Health Addiction Agencies, Inc.
Philip Lubitz	National Alliance on Mental Illness
Gurpreet Kaur	National Holistic Counseling
Maureen Shea	New Jersey Association of Community Providers
Deborah Polacek	New Jersey Family Planning League

ATTENDEES:

Melissa Chalker	New Jersey Foundation for Aging
Ray Castro	New Jersey Policy Prospective
Selina Haq	New Jersey Primary Care Association
Mike Bond	Novo Nordisk
Alison Handler	Novo Nordisk
James McCracken	Ombudsman for the Institutionalized Elderly
Karen Shablin	Optum
Tom Pyle	Parent/Member of Mental health Planning Council
Matt D'Oria	PerformCare NJ
Dean Gianarkis	Pfizer, Inc.
Mary Kay Roberts	Riker Danzig
Bill Cahill	United Healthcare Community Plan
Zinke McGeady	Values Into Action
Karl Dehm	VNSNY CHOICE Health Plans
Victoria Izraylevsky	VNSNY CHOICE Health Plans
Molly Auciello	Wellcare
John Kirchner	Wellcare
Dawn Apgar	Department of Human Services
Lowell Ayre	Department of Human Services
Vicki Fresolone	Department of Human Services
Nancy Hopkins	Department of Human Services
Dr. Marin Zanna	Department of Human Services
Brian Francz	Department of the Treasury
Ben Neville	Department of the Treasury
Nancy Day	Division of Aging Services
Kathy Mason	Division of Aging Services
Maribeth Robenolt	Division of Developmental Disabilities
Karen Kasick	Division of Family Development
Joe Bongiovanni	Division of Medical Assistance and Health Services
Meghan Davey	Division of Medical Assistance and Health Services
Robert Durborow	Division of Medical Assistance and Health Services
Liz Fortunato	Division of Medical Assistance and Health Services
Marla Golden	Division of Medical Assistance and Health Services
Holli Arnold	Division of Medical Assistance and Health Services
Carol Grant	Division of Medical Assistance and Health Services

ATTENDEES:

Marcia Harrison	Division of Medical Assistance and Health Services
Kim Hatch	Division of Medical Assistance and Health Services
Richard Hurd	Division of Medical Assistance and Health Services
Dr. Tom Lind	Division of Medical Assistance and Health Services
Phyllis Melendez	Division of Medical Assistance and Health Services
Jennifer Petrino	Division of Medical Assistance and Health Services
Michelle Pawelczak	Division of Medical Assistance and Health Services
Dianna Rosenheim	Division of Medical Assistance and Health Services
Heidi Smith	Division of Medical Assistance and Health Services
Margaret Springer	Division of Medical Assistance and Health Services
Irina Stuchinsky	Division of Medical Assistance and Health Services

5

DR. SPITALNIK: Good morning. My name is Deborah Spitalnik. I'm the Chair of the Medical Assistance Advisory Committee, and it is my delight to welcome everyone. Adequate notice of the meeting has been provided and the meeting has been advertised publicly. The public notice was filed with the New Jersey Secretary of State on December 17th of 2012. It was posted on the Department of Human Services website.

It was also posted in the Medical Assistance Customer Centers and the County Boards of Social Services, and appeared in the following newspapers on December 20th: The Atlantic City Press, The Bergen Record, The Camden Courier Post, The Star Ledger, The Trenton Times. And this public notice was also published in the New Jersey Register on January 7, 2013.

We have new membership today, which we are delighted and grateful to Governor Christie and to the staff of the Appointments and Authorities Office, and a particular thank you to Judith Lieberman and the staff of the Department of Human Services. In a moment, I will ask the new members to introduce themselves and then the members of the public.

I ask that when there is the opportunity for comments and discussion and questions that the members

6

of the Medical Assistance Advisory Council (MAAC) have the opportunity to do so first, and then the members of the public, including our sister state agencies. We've never had to enforce a time limit but I will assert the prerogative of the chair if we need to move along.

So having said that, I am delighted that we have now come up to complement in membership of the MAAC. I want to thank our colleagues and former MAAC members Valerie Power-Smith and Patricia Kleppinger for their service on the MAAC. Our colleagues Mary Coogan and Wayne Vivian are in holdover status, so were not formally announced. And now joining us, the MAAC members are Sherl Brand, Eileen Coyne, Mary Coogan, Theresa Edelstein, Jay Jimenez, Dennis Lafer, Dot Libman, Mary Lund, Beverly Roberts, myself, Wayne Vivian, and Dr. Sydney Whitman. I have the listing of how people were appointed. And some of us who have been in some status have now shifted into others. So Beverly Roberts is now appointed in a consumer slot, replacing Pat Kleppinger who was a holdover whose term expired in 2008. Dennis Lafer replaced Linda Garibaldi, who resigned I'm replacing Ellen Grassman resigned. Eileen Coyne is replacing Valerie Power-Smith, whose term expired in 2006. Jay Jimenez was reappointed. Dr. Whitman is reappointed. Theresa

7

Edelstein was replacing Lowell Arye, who resigned. Dot Libman replaces Carol Kent, who resigned. Mary Lund replaces the slot that Beverly Roberts was in. And Sherl Brand is replacing the slot that I was in.

We are exceedingly grateful that we are now up to compliment. The State Board of Human Services will need to confirm the appointments and reappointments, and we will receive official notification from the State Board. We also understand that candidates who had applied to the Governor's Office for appointment and who may have been vetted but not selected do not receive formal notification from the Governor's Office. So I will say informally a thank you to everyone for their interest in the MAAC. We will continue to work with the Department of Human Services and the Governor's Appointments Office to gain a fuller understanding of people's status.

I want to welcome everyone, and I'm going to ask people to introduce themselves. I'm going to ask everyone on the MAAC to introduce themselves. I've explained the seats that people are in, but I'd ask you to very briefly describe the constituency you represent each other. And then, as is our custom, I'll ask the members of the public to introduce themselves.

So may I start with Eileen Coyne,

8

please.

MS. COYNE: Good morning. My name is Eileen Coyne. I guess first and foremost I am parent of a 24-year-old son that has developmental and intellectual disabilities, which threw me in a world from being an insurance producer into developmental disabilities and human services. I used to work at the Council on Developmental Disabilities under family support. Then I moved on to support coordination working first for UMDNJ, then Neighbors, and now Caregivers of New Jersey. We do support coordination in self directed services. I'm also the Vice Chair of the Ocean County Long Term Recovery Group for those who are recovering in Ocean County from Super Storm Sandy. And I'm very pleased to sit on this Council. Thank you.

MR. WHITMAN: Syd Whitman. I'm a pediatric dentist. I'm Chairman of the Oral Health Coalition. I'm Chairman of Pediatric Dentistry for Beth Israel Medical Center. I'm also Chairman of Head Start for New Jersey for the dental section. I'm also Chairman of what used to be called Foundation Dentistry for the Handicapped. And those are just some of the my titles.

MR. VIVIAN: Thank you. My name is Wayne Vivian. I'm the president of the Coalition of Mental Health Consumer Organizations, and in my day job I work

for the Residential Intensive Support Team as a Senior Staff Specialist. I represent consumers and mental health consumers. And I'm also a Medicaid recipient who gets Medicaid through WorkAbility. Thank you.

MR. LAFER: Good morning. My name is Dennis Lafer. I'm currently a consultant in the mental health field. My previous job had been as Director and Deputy Director of the Division of Mental Health.

MS. HARR: I'm Valerie Harr, I'm the Director the Division of Medical Assistance and Health Services (DMAHS).

DR. SPITALNIK: I'm Deborah Spitalnik. I'm the Executive Director of the Boggs Center on Developmental Disabilities, New Jersey's federally designated University Center for Excellence in developmental disabilities at Robert Wood Johnson Medical School, where I'm also a professor of pediatrics.

MS. EDELSTEIN: Good morning. I'm Theresa Edelstein. I'm Vice President of Post-Acute Care Policy at the New Jersey Hospital Association where I work with our long-term care, home health, PACE and other members. And a little known fact, I'm a licensed nursing home administrator as well.

MS. COOGAN: Mary Coogan, Advocates for

Children of New Jersey.

MS. ROBERTS: Beverly Roberts, I'm Director a health care advocacy program called Mainstreaming Medical Care at the Arc of New Jersey. We serve those with developmental disabilities.

MS. LIBMAN: Hi. Dorothea Libman, better known as Dot. I'm Director of Pride Programs, which is the programs for adults over 21 with developmental disabilities for the ECLC of New Jersey schools. We have three Centers, plus a Work Center in Chatham and a Center in Paramus. And I'm very honored to be appointed to this Council.

DR. SPITALNIK: And Valerie, are you on the phone?

MS. POWER-SMITH: Yes, I am.

DR. SPITALNIK: And we have on the phone Valerie Powers-Smith who recently just rotated off the MAAC.

MS. POWERS-SMITH: Good morning.

DR. SPITALNIK: Good morning. Before I ask the public to introduce themselves, I want to thank Director Harr, Phyllis Melendez, and Kim Hatch for their support of the MAAC and these processes.

(Attendees introduce themselves.)

DR. SPITALNIK: Thank you all and welcome

all. As we can see there's always continuing interest in our work, and we're deeply appreciative of that. From our last meeting in January, we experimented with having a transcript of the meeting rather than bullet point minutes. Let me ask if there's any input on corrections to the transcript?

So may I have a motion to accept the transcript as minutes.

MS. ROBERTS: Make a motion to accept the transcript as minutes.

DR. SPITALNIK: Roberts. Second?

MR. HITTMAN: Second.

DR. SPITALNIK: Whitman.

All those in favor?

MEMBERS: Aye.

DR. SPITALNIK: Opposed? Abstentions?

Those are accepted as minutes.

We had moved to the format of doing a transcript because our proceedings are so voluminous, so it's really almost impossible to take full notes. I'd like a sense of the MAAC whether we would like to have bulleted minutes or highlights from the transcript, or whether we would continue to rely on the transcript or whether we would experiment between now and the next meeting and see what feels helpful. And

maybe we should reserve decision until the new members have a sense of process.

What's your pleasure about that issue?

MS. COOGAN: I would say let's see how it goes with the transcript. And then if people feel like the bulleted mechanism would be better, we can always decide that later.

DR. SPITALNIK: Other thoughts.

MS. ROBERTS: I'd like to give an opportunity for the new members to also to give their input.

DR. SPITALNIK: Okay. And my sense would be that reading through the transcript would be useful to the new members as an orientation.

MS. COYNE: I did read the transcript. I thought it was very helpful for me to be here today.

MS. LIBMAN: Me too.

DR. SPITALNIK: Thank you. So we'll proceed in that way.

And I thank the transcriptionist for your assistance.

The next item of business is a report from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Workgroup.

Valerie, do you want to give us a quick

orientation with what the CAHPS® is and then we can report out where we are with that? Thank you.

MS. HARR: The CAHPS® is a consumer survey of Medicaid recipients. It is a federal requirement that states that have a Medicaid managed care program do an annual consumer satisfaction survey. And we subcontract with a vendor to conduct the survey, pull the results together and issue a report.

There are a standard set of questions that you must use under the CAHPS®, and then there is also optional questions. There are limitations to the extent that the CAHPS® survey really gets at meaningful information from a survey, but it's essentially the national standard and nationally recognized. All states that I know are using the CAHPS® survey.

So we have struggled through the years on how to maximize the benefit of the consumer satisfaction survey. And with that, every year as we plan for the next year, the MAAC reviews the previous year's results, and then we look forward to what can we do to improve the response rate as well as the quality and the meaningfulness of the result. So that led us to create this workgroup to try to continue to improve the quality of that product.

DR. SPITALNIK: Thank you so much for that

orientation. So a workgroup was convened on February 15th. Mary Coogan, Beverly Roberts, and myself from the MAAC; and from the Division of Medical Assistance, Valerie Harr, Richard Hurd, Holly Arnold, and Phyllis Melendez. There are standard questions, and then there are also supplemental questions. And the CAHPS® is divided into child and adult questions. We agreed to add 11 adult supplemental questions and 5 child supplemental questions.

There is also a CAHPS® tool that is a national survey of children with special health care needs. There's the Centers for Disease Control and Prevention's National Survey of Children with Special Health Care Needs that Beverly Roberts suggested. There's also a supplemental questionnaire of children with chronic conditions. The constraints or the requirements of the CAHPS® requires that if you are administrating an additional tool to say about children with chronic conditions, it has to be administered to all children. And in a subsequent e-mail exchange, we tabled adding an additional children's questionnaire, with the idea that we would like to consider that in the broader context of quality. DMAHS is currently reviewing quality measures for the new Comprehensive Medicaid Waiver (CMW) Managed Long Term Services and

Support (MLTSS). And we thought that there might be a more fruitful avenue than the CAHPS® with its limitations for getting at the issues of quality.

Does anyone from the MAAC or from the DMAHS staff who want to add anything at this point?

MS. COOGAN: No. I think that is was discussed at the MAAC.

An additional thought that I had after the meeting was that once the survey goes out, if it was possible to notify us when it was going out then maybe members of the MAAC and also members of the audience who do send out E-news on newsletters could reference it that it's going and alert our population to be on the lookout for it and to please respond. We thought that might help generate more responses.

MS. HARR: Dick, can you tell me did the survey go out?

MR. HURD: 35,000 were sent out the middle of March.

MS. HARR: And when are the surveys due.

MR. HURD: They have to report to the national organization by the end of June, so between now and the end of June, Xerox will be compiling all the data when we get the responses.

MS. HARR: But there's no deadline for the

consumer in returning the survey?

MR. HURD: No. Xerox sends out two or three reminder notices if they don't get them, and that's going on over the next month or so.

MS. COOGAN: So are the surveys coming from Xerox, or are they coming from the State?

MR. HURD: The surveys come from Xerox, but they are printed on NJ FamilyCare letterhead.

DR. SPITALNIK: What I would ask is that the Division prepare a standard paragraph that could then be disseminated to members of the MAAC and other advocacy groups so that a standardized prompt is sent out to encourage people.

MR. HURD: I can get copies of the letter and the reminder notice that is mailed to clients.

DR. SPITALNIK: Thank you.

Anything else? Anyone from the public?

MR. MANGER: Joe Manger from Horizon NJ Health. I would just caution everyone about that it's the standard message given and not any message about how to respond, because you get into a fine line when you're doing those surveys and there's a lot of guidelines about what you can and should not say or do. So if we can just make sure that that accompanies that notification.

DR. SPITALNIK: Yes. Thank you. That's why I had a standard paragraph because we need to be judicious that we don't prejudice results in any way. Thank you for that.

Anything else about the CAHPS®?

Hearing none. And thank you to the Division's staff both for what they do with the CAHPS® and also for their collaboration.

MS. ROBERTS: Moving forward, were you going to talk now about the next step?

DR. SPITALNIK: Next, we want to look at quality in the larger context of the broader quality strategy.

MS. ROBERTS: What I would like to do is to start now with thinking about what we're going to do with the next Survey. I would like to start that process.

DR. SPITALNIK: Thank you.

Anyone else?

MR. LUBITZ: Phil Lubitz. You may want to consider making a decision whether you want to have a subcommittee now that you have a larger group working on the CAHPS® or merely form a subcommittee who specifically would be thinking about quality, including the CAHPS® or who may consider other endeavors that you

might think worthwhile for the Division.

MS. HARR: Agreed. We are working on a quality strategy plan as part of the CMW and in preparation of moving to MLTSS. Carol Grant is chairing the Quality Workgroup. I would like to bring the quality strategy plan to the MAAC membership and have discussion and feedback on the broader quality strategy plan, because this is a component of a much, much broader quality plan.

DR. SPITALNIK: Beverly, are you comfortable with that?

MS. ROBERTS: Do you have any idea of the timeframe that we're talking about for working on the next CAHPS® Survey?

MR. LAFER: When do the Survey results have to be in in order to get the information prepared for next year? What's the time period in that respect?

MS. HARR: For the CAHPS®, January.

MR. HURD: The results get uploaded to a database at the end of June, but the Report is available in November, approximately.

DR. SPITALNIK: The question is for 2014, when would we engage the issue of the supplemental questions for the children's survey? What would be the time frame going forward that we would need to have

acted or made recommendations?

MR. HURD: The Survey has to go out in early March so we have to address the issue in the December or January time frame.

DR. SPITALNIK: So that seems like a workable time frame. Does that feel comfortable?

MR. LUBITZ: I think I was suggesting something other than that, not tying your quality strategy to that one Survey. Because if you do that, you're caught with the limits of that Survey. So again, thinking of time frames, consider the time frames of that Survey has to be placed, but that should only be one small element of a quality strategy.

DR. SPITALNIK: Yes. I think we're very much in concurrence. And that's why I was suggesting that we wait about talking about the CAHPS® so that it's in the context of the broader quality strategy. So we very much in agreement with that point of view.

Anything else on the issue of quality?

Will we have an update prior to October?

MS. HARR: Yes.

DR. SPITALNIK: So at our next meeting, which is in June, we can have an update on quality and then figure out how we organize ourselves in our advisory role relative to that strategy. Is that

acceptable?

MS. ROBERTS: Yes.

DR. SPITALNIK: All right. Thank you.

We'll move on to the Director's Report and to Valerie Harr.

MS. HARR: Thank you. So I am going to backtrack a little bit because we have new members. Originally, under the Federal Affordable Care Act, it was mandatory that states expand their Medicaid for all non-elderly adults up to 133 percent of poverty. With the challenge at the Supreme Court level and the ruling from the US Supreme Court, Expansion became optional to states. So you may have seen every time a state made an announcement, there was a lot of press. So as part of Governor Christie's recommended budget for State Fiscal Year 2014, the Governor announced that New Jersey would elect to do the optional Medicaid Expansion.

This Council had provided a letter of recommendation to the Governor to expand the Medicaid program in New Jersey, so I want to thank the MAAC for that letter.

The last time we met was prior to the Governor's budget address. So I do want to go over some numbers with you.

With the Expansion of Medicaid, states must start accepting applications for the Expansion on October 1, 2013. The Expansion would be effective January 1, 2014. New Jersey has a history of having done multiple Expansions previously, so our picture of the impact of the Expansion is different from other states. So with that, there is one adult population that we have not previously covered. And they are adults without dependent children or childless adults. We had covered that group up to only 24 percent of poverty previously. So by expanding Medicaid in 2014 to 133 percent of poverty, we're expecting about 101,000 childless adults to become newly eligible for Medicaid.

In addition, as states have done the analysis and there's been different groups across the country analyzing what would happen under the Expansion, they do expect, as people learn about the federal Marketplace and the topic of insurance becomes more than norm, that people that have not been previously eligible for State Medicaid programs will take advantage of the program.

If that's the case, based on our estimates, and we work closely with the Rutgers Center for State Health Policy in refining our estimates, we could have

as many as 192,000 both children and adults who had been previously eligible for Medicaid, but for a variety of reasons had not enrolled in our programs. So that brings us close to 300,000 individuals that could be newly eligible to our NJ FamilyCare and Medicaid program.

So as I mentioned, New Jersey had already expanded to parents. We have expanded in the past. We scaled the program back, we've frozen it, we've done different things. There are a group of parents that qualify for NJ FamilyCare (NJFC) currently through an enhanced earned income disregard. There are about 145,000 of these parents. They will be newly eligible for Medicaid. That's where there's significant savings opportunity for the State because we will go from a 65 percent federal match to a hundred percent federal match on those parents, at least for the first few years, and then the formula scales down.

In addition, I mentioned there's childless adults that are about 24 percent of poverty that we historically have been covering. There are about 44,000 of those childless adults. They will also be considered newly eligible with a hundred percent federal funding.

Since New Jersey had done previous

expansions, there's significant savings to the State of New Jersey by electing the Expansion because of the change in the federal matching rates of those groups.

We do have about 14,000 parents between 134 percent of poverty and 200 percent of poverty. That program's been frozen, but we still have 14,000 parents. Our authority to cover them expires in December 2013. We will do a renewal and those parents may become newly eligible under the new way that income will be calculated under the Affordable Care Act. It's called Modified Adjusted Gross Income (MAGI). So regardless of whether or not we would be doing the Expansion, we will be changing the way Medicaid eligibility is determined for most of our population, excluding the aged, blind and disabled and some other populations. But those parents would either become newly eligible or they will be transitioned to the federal Marketplace where they may be eligible for a premium subsidy.

So that summarizes where we are with the Expansion.

Any questions?

MS. COOGAN: The new Marketplace would be the federal Exchange?

MS. HARR: The federal Marketplace, yes.

They changed the terminology. It's not the Exchange any longer.

MS. ROBERTS: A quick question. I've dealt with families currently when they have a certain income, but then if there's a certain month where they get five paychecks instead of four during that month, it throws things off. Is that going to be rectified within the system?

MS. HARR: I think you're probably talking about someone who's applying through the Aged, Blind or Disabled program.

MS. ROBERTS: I'm concerned specifically about the coverage for the child when the family income has more paychecks in a month and, it has been detrimental for the child through NJFC.

MS. COOGAN: You mean it would bump them up.

MS. ROBERTS: It would bump them up over because of a certain month. A month where they got four paychecks during the month, they'd be fine. So I'm trying to differentiate Aged, Blind and Disabled eligibility versus our Medicaid and NJFC.

My question specifically now is children under the age of 18 who are getting NJFC because of the family income all together.

MS. HARR: We have submitted all of our

documentation to the Centers for Medicare and Medicaid Services (CMS) in terms of how we do eligibility now. It is with Rand, their contractor. We're waiting to hear back from Rand on how we do eligibility and how that will be converted.

Elena, can you address this? I don't know if sometimes having extra week or the fifth week of pay gets resolved under MAGI.

ELENA: No, it's actually an Social Security (SSI) rule. It's not on the Medicaid side, it's on the SSI side where they count all the income received in that month, where we do prorated share. I don't know that it's going change because, again, it's on the disabled side, so I don't know that any of that changes, but we'll certainly take a look at it.

MS. ROBERTS: The particular question I was asking was for children who have a disability but they're not SSI because they're under the age of 18 and they were getting NJFC and looking at the whole family income. But in times when the family income exceeded the maximum amount --

ELENA: I could talk to you later, but that's not our rule. Our rule is monthly income, we prorate it. SSI does look at it differently.

MS. HARR: As I said, I think with MAGI, it

would be based on your most recent income tax filing. It won't be a calculation of pay stubs the way we do it today. I can't say with certainty if that will be an improvement in terms of those families until we see some actual cases after the change.

DR. SPITALNIK: Thank you. Other questions just about Medicaid Expansion from the MAAC?

Dennis.

MR. LAFER: So when we read about Medicaid Expansion, it's usually out of the eligibility side. I'm wondering if you can just talk a little as what would they be eligible for? What are the services?

MS. HARR: Our team has been meeting regularly to work through a lot of these issues. We received technical assistance from the Robert Wood Johnson Foundation and the Center for Healthcare Strategies and a Consulting Group.

We have to select a benefit package. It's called the Alternative Benefit Plan (ABP). We're going through the analysis right now. The ABP must include ten essential health benefits that are also required for the Marketplace products. By June, we expect to have some idea of the ABP.

MR. LAFER: Some of the most effective programs are the optional service package programs. So

I hope those will be considered in your analysis.

DR. SPITALNIK: A Medicaid Expansion question from the public?

MR. ROONEY: Michael Rooney with Alkermes. The 101,000 single adults and childless couples are they considered newly eligible?

MS. HARR: Yes. MR. ROONEY: Are the 44,000 part of the 101,000?

MS. HARR: No. They are in addition to the 101,000. We have historically been covering the 44,000 childless adults only up to about 24 percent of poverty. So by going from 24 percent of poverty to 133 percent of poverty, we will have an estimated another 101,000 individuals.

MR. ROONEY: Thank you.

MR. CASTRO: Ray Castro, New Jersey Policy Perspective. I want you to comment on the issue of coordinating benefits and families where the parent is now eligible for the Medicaid Expansion and the child is in NJFC. There seems to be a management issue and a funding issue. The management issue being that the federal government requires that the Medicaid agency coordinate those benefits. It seems to indicate that Medicaid or the County Welfare Agency (CWA), would need some understanding of the Marketplace. I'm wondering

organizationally are you going to have special units to deal with that?

And the other issue is funding, which is that now in addition to the parent having to pay the cost share for the child, they're also going to have to pay for their own cost share, which could be quite considerable in the Marketplace. And I know some states are considering providing a waiver for the child so that the parent is not overwhelmed with both payments. I'm wondering if you looked at that issue as well.

MS. HARR: The issue of coordination has been raised, and I've had a call with the U.S. Department of Health and Human Services (HHS) Regional Office. I think there are still a lot of unknowns. There's an expectation about coordination and yet I don't know what will be offered in the Marketplace for New Jersey residents. So it's very difficult to try to plan coordination when I don't yet know -- it would be a lot easier if I know that a health plan that Medicaid is contracting with will also have a product in the Marketplace and what that product will be. That coordination, in some respects, happens now as people lose coverage and become Medicaid eligible. I'm still expecting that the Medicaid benefit package will be

richer than what's offered in the Marketplace. So we know that there are Medicaid services like transportation that will not be offered in a Marketplace product.

So regarding the coordination with the Marketplace, we continue to have conversations and we are working with the Robert Wood Johnson Foundation and having conversations with HHS on that. I know the topic of outreach has come up previously. Again, I'm talking to the Robert Wood Johnson Foundation and HHS about outreach opportunities. I think some of the most success we've had is around in-reach so we want to continue to look at other divisions and departments in the State to make sure that they're getting the word out and that we continue to make sure that people know that we continue to cover children in NJFC, that people know that all of the Medicaid and NJFC programs that we have are available. We're talking about putting things on our website and preparing material in coordination, hopefully, with HHS, that we will make available to you so that you can share as well. We're going to try to maximize, again, on those relationships and notices and programs that we have in place so that people understand and know about the Medicaid Expansion and other existing programs.

MR. VIVIAN: In the future, the adults now, the parent, their eligibility for Medicaid will no longer be dependent on if their child gets Medicaid? In the past it was that the parent was only eligible because the child was eligible.

MS. HARR: Right. So all non-Aged, Blind and Disabled adults would be eligible up to 133 percent poverty regardless of the child. Now, we would continue to cover children up to 350 percent of poverty. So under the Affordable Care Act, you could have a parent eligible for a subsidy and getting something through the federal Marketplace and the child would still be eligible for NJFC.

MR. SPIELBERG: Josh Spielberg with Legal Services of New Jersey.

Valerie, when you were going through the list of populations that would now be covered, I didn't hear you mention the parents who had lost coverage as a result of the 2010 change in eligibility.

Now, I think that category which is now 14,000, they're lumped into that category, it used to be at 60,000. So they're about 45,000 parents who lost coverage, some of them may be between 133 and 200 percent, but many of them are under 133 because they have unearned income that made them ineligible for the

program with the adjusted rule. So do you have an estimate of how many of that group that lost coverage will regain coverage under the Expansion?

MS. HARR: No, I don't have an estimate of that. But you're right. That's why I said 14,000 parents that I have sort lumped into that group that will do a renewal because we will not have disregards like we do today. Some of those parents are newly eligible and some will go into the Marketplace.

The 45,000 that you're talking about, to the extent that they are newly eligible will be because of the way income has changed in terms of the MAGI, I'm assuming they are part of my estimate of about 200,000 people that would become eligible. When Rutgers did their analysis, they didn't differentiate between with those disregards. I'm expecting that in that 200,000 includes individuals that currently are not qualifying because they don't have the enhanced earned income disregard, but many of them will be eligible under MAGI.

Does that answer?

MR. SPIELBERG: I think so. You're talking about the 192,000 that were eligible but not enrolled?

MS. HARR: Yes, because Rutgers didn't know the distinction. They assumed that those individuals

have been eligible.

MR. SPIELBERG: I see.

MR. PYLE: I'm Tom Pyle, father of a dual eligible with a psychiatric disability. I'm asking about the numbers that you cited, 101,000 who are newly eligible? What is your estimate of what that cost will be to the Medicaid system? And of the total number what percentage of that number are you estimating to be those who have psychiatric disabilities who will then be coming into the Medicaid system because of the Medicaid Expansion?

MS. HARR: I don't have that number with me in terms of the cost of those that are currently eligible but not enrolled, but there was a cost. But when I talked about the opportunity of the 100 percent federal funding for the 145,000 parents and the other 44,000, it significantly offsets the cost of moms and kids that are currently eligible for Medicaid that haven't enrolled, and then we would get our regular match. So I don't have that number with me, but the savings offsets that cost. But you're right; there is a cost.

MR. PYLE: So can I just clarify? Are you transferring some people because of this, from an old match to a new match because some of their eligibility

which then offsets the additional cost of the 192,000 that will be reimbursed?

MS. HARR: Right. So of the 145,00 parents and 44,000 childless adults that will be transitioned from either the NJFC match or the 50 percent match under our current 1115 Waiver to 100 percent federal funding for the first three years, and then it drops down over the course of another three years to 90 percent federal match indefinitely.

So your other question. We had previously in 2000 covered childless adults up to 100 percent of poverty with 100 percent State funds. We reexamined our claims information from that population, and we do expect that the newly eligible population will have greater costs and greater health needs than, say, some other populations. I don't have an exact percent of how many will have a psychiatric illness or a mental health need, but we are expecting that it will be significant which is why I've been working with the Division of Mental Health and Addiction Services to make sure that we have really what we think would be an appropriate mental health and substance abuse benefit to meet the needs of the expanded population.

MS. ORLOWSKI: Hi. I'm Gwen Orlowski from Legal Services of New Jersey.

My question goes to screening people for programs that they might be eligible for under the Expansion. And these numbers may well be small, but people who are currently on Waivers or in nursing homes, that have income between a hundred percent of poverty and three times the federal SSI level, who lose clinical eligibility, but their incomes now may be between 100 and 133, are there plans to screen those people before terminating them from Medicaid?

MS. HARR: Yes. There should be screening happening now before anybody loses eligibility to see if they would be eligible for any other Medicaid program.

MS. ORLOWSKI: With all due respect, this is not always happening. I have people who are eligible for Global Options who are terminated at the county level without being screened for Global Options.

MS. HARR: So we'll take that back, but certainly my expectation is that everybody would be screened at our redetermination or renewal to see if they are eligible for any other Medicaid program. The County Welfare Agencies will be trained on the Expansion and how to do the new MAGI calculation.

MS. ORLOWSKI: But the termination comes out of the Division of Aging Services; it doesn't come out

of the CWA.

MS. MASON: One may have the clinical eligibility determination, but then it should go back to the Board of Social Services for financial eligibility determination.

MS. HARR: And at that point, if they no longer meet that nursing home level of care, they should be screened for other Medicaid programs. So we'll take that back as something to make sure we recognize.

DR. SPITALNIK: Thank you.

Valerie, the next item is the Accountable Care Organization (ACO) update.

MS. HARR: The State statute was passed that requires the Medicaid agency to do an Accountable Care Organization demonstration. Prior to us implementing this demonstration, we need to promulgate regulations. The originator of this has been the Camden Coalition, on drafting these regulations. But one obstacle that we had is that this demonstration allows that if the ACO demonstrates success and saves Medicaid dollars, that some of that savings goes back to the ACO physicians and they can share it with the members of their ACO and providers. That shared savings really sets off red flags with other federal partners. So it

requires several conversations with the Department of Justice and other federal regulators. So it's taken some time to tease out the regulations, but they are with our Office of Administrative Law. They sent back many, many questions that we've responded to. Now, this is just a target date, but we're hoping that they get published in the New Jersey Register for public comment in May 2013.

In addition, we have submitted a concept paper to CMS on the Accountable Care Organization. We're going to have a conversation about to what extent do we need a State Plan Amendment to do this demonstration.

So our planned timeline, again, subject to change, the public comment May 2013 on the regulations. Regulations finalized in August or September 2013, our deadline on receiving applications to be an Accountable Care Organization will be 30 days after the Regulations are finalized. So if they're finalized in August or September, our application deadline would be September or October 2013 and we would have a project start date of January 2014. So that's the timeline.

We do already have one application that we received, so that applicant isn't waiting for the Regulations. They may need to change based on review

of Regulations, but we know one entity that is feeling that they're prepared to start.

DR. SPITALNIK: Any questions about the ACO demonstration?

Seeing none, from the MAAC, any questions from the public about the ACO demonstration?

Thank you. Let's move on.

MS. HARR: You heard Dr. Lind introduce himself. He's been leading a Credentialing Task Force. The goal is to try to provide streamlined unified credentialing process for medical, dental, and mental health, and non-traditional providers in New Jersey. That's the goal. I think we probably will start small just within the Medicaid program, but there's a vision that will be unified credentialing, maybe even with commercial insurance. The Credentialing Task Force was formed and a series of goals developed at the February 26, 2013 medical and dental directors meeting -- the medical and dental directors of our Managed Care Organizations (MCOs), as well as our staff and it also includes representatives from the Department of Banking and Insurance, other folks from the Department of Human Services, the Medicaid Fraud Division, and the provider community.

The next meeting of that Credentialing Task

Force is being scheduled to meet in April 2013, and we will continue to meet every one to two months until such time that there is a formal recommendation on how to work with the streamlining or credentialing between our health plans.

DR. SPITALNIK: Any questions?

MS. ROBERTS: Thank you for this. Is there a target time when this might be finalized?

DR. LIND: Beverly, I'm hoping that we're going to get a recommendation within six to seven months.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Okay. Thank you. And thank you Dr. Lind.

Grievances and appeal reporting update.

MS. HARR: We have over 90 percent of our 1.3 million Medicaid recipients now in managed care. In order to ensure that members of Managed Care Organizations have their rights to file complaints, appeals, and grievances, our managed care contract requires that that MCOs submit quarterly reports to us on the status of complaints, appeals, and grievances. It contractually requires that the MCO allow the members a time frame of no less than 60 days and no greater than 90 days to file Stage 1 or Stage 2 appeal,

and four months for Stage 3.

Now, the Affordable Care Act (ACA) changes the complaints and grievances process with commercial insurance. We have historically tried to align the Medicaid rules with Department of Banking and Insurance rules so with that, there was a change effective January 2013, we amended the managed care contract to reflect Department of Banking and Insurance regulation, also because I think the Stage 3 appeals go to the Department of Banking and Insurance, so we have to make sure that we're consistent and aligned there. But that change no longer requires a member to request a continuation of benefits during the appeal process. So previously, if a member requested an appeal, they had to elect if they wanted a continuation of benefits; you had to check-off a box. With the Affordable Care Act changes, the member no longer has to request; it's automatic.

This is under the scope of our Office of Quality Assurance. And Carol Grant, our Chief of Operations, is here in the audience.

So at the request of the MAAC, we're trying to gather, compile our fair hearing statistics. I do have some and will continue to refine them and present them to you in MAAC meetings. A member has an

opportunity to file a grievance or appeal through the managed care organization (MCO). A Medicare recipient also has the opportunity to file for fair hearings through the Medicaid agency. So here are our statistics on the fair hearings filed with the Medicaid agency, 76 cases are related to United and they are in various stages of the appeal process. We have eight that are with Horizon and three with Amerigroup.

So with respect to the third quarter of 2012, the majority of the top five categories of member utilization complaints and grievances were for denial of inpatient hospital stays, denial of home health services considered not medically necessary, denial of Durable Medical Equipment (DME), and the remainder fall under "other."

Most of our complaints, appeals, and grievances are resolved internally with the Managed Care Organization at the first or second stage level. Any appeal reaching Stage 3 would require an external review by the Independent Review Organization (IRO). As I said, the Stage 3 appeals do go to the Department of Banking and Insurance.

So let me clarify, are those fair hearings or are those complaints and grievances captured by the MCO, Carol?

MS. GRANT: The 80-some-odd cases are fair hearings. The other numbers are through the internal health maintenance organization (HMO) recording and the complaint database.

MS. HARR: Okay. In addition, the Office of Quality Assurance receives complaints as well. And those complaints are tracked in a database according to the same Banking and Insurance categories.

MR. VIVIAN: The fair hearings are for denials of services generally?

CAROL: Both could be denials of service, but you do have two options.

MR. VIVIAN: Is this annually?

MS. HARR: No, it's quarterly.

MS. ROBERTS: So that was 80 fair hearings in one quarter?

MS. HARR: Yes. DR. SPITALNIK: Are there questions from the MAAC?

MS. ROBERTS: Thank you. Obviously, this is something that I'm very, very interested in, and I know we have other agenda items so we can't take an extended amount of time. Would it be possible for this information to be sent out electronically?

MS. HARR: Yes. So those 80 are fair hearings. So we said in October, hopefully we'll have

more information for you on the complaints and grievances that are coming from the HMO quarterly reports, as well as what's going to the Office of Quality Assurance.

MS. ROBERTS: Quarterly is fine, but can we get an annual picture?

MS. HARR: Yes.

MS. ROBERTS: It appears as though a gigantic number of the group of 80 were from one particular HMO.

MS. HARR: Yes, 76 were United; 8 were Horizon; 3, Amerigroup.

MS. ROBERTS: I'm curious as to when there's such a huge amount coming from one HMO specifically, does anything happen when you see that volume from one particular HMO?

MS. HARR: Yes. The fair hearings will go to the Office of Administrative Law. So it's not the Medicaid agency that will be a part of that fair hearing. But, yes, we're aware of those, and so the Office of Quality Assurance (OQA) is looking at the reports that we received from the Managed Care Organization, as well as the complaints and grievances. And, yes, we take administrative action when we think it's appropriate. OQA meets with clinical staff. Dr.

Lind meets with the medical directors, and we do try to get to the cause, especially if there seems to be some systematic reason that there's a trend or a high volume.

MR. VIVIAN: That could just be a spike. You never know. That's why you would have see it over a duration.

MS. ROBERTS: And I would like to see the annual numbers.

MS. HARR: We did see the numbers increase as we moved different populations to services. So we need to have some time see what the trend is. But certainly, we know about these things based on the calls coming in. Also, we address the issues immediately regardless of what's happening with the fair hearings.

MR. LAFER: So will we find out how these were adjudicated?

MS. HARR: Yes. Know that the majority of those 9 cases were withdrawn. I don't know the reason for the withdrawal of the cases, but yes.

This is very new for us to be reporting this type of information. So it's a work in progress, but we will continue to have this topic and to try to provide information.

DR. SPITALNIK: Thank you.

Other questions from the MAAC?

Gwen.

MS. ORLOWSKI: Gwen Orlowski again from Legal Services of New Jersey. So we actually get some calls on these cases at Legal Services of New Jersey, and I have a couple of quick observations.

Primarily we see calls about Personal Care Assistance (PCA) services, and some of them have been denials or terminations and a lot have been reductions in hours.

United Health Care have an outside counsel who is excellent. All I have to do is get on the phone with her and we can begin to resolve issues. I've had really good experiences with United counsel, so just I wanted to go on the record with that.

A couple quick things. The letter that goes out from all of the MCOs is absolutely horrible. I can't read them. The clients cannot read them. It would be good if we could work on getting a letter that was more clear, especially when you go to that third level appeal. It's very confusing for consumers.

The second point is that for people to understand why the decision was made, they really need a copy of the PCA Assessment Tool. It's not coming

with the reductions in hours or the terminations. The Division of Aging Services now, when they do a termination, are sending a copy of the New Jersey Choice Assessment Tool so people know how they've been assessed. And it's really difficult for the consumer to get that PCA Assessment Tool unless I'm involved, and then we can get them. But in our opinion, it should just be rote that the Tool goes out so people see how they were assessed and maybe correct it in the moment.

And the third thing is people are not getting their continued benefits on PCA hours. We have current cases right now where it involved a reduction in hours, and absolutely those folks are getting the reduced amount of hours unless we get on the phone and call and change it.

DR. SPITALNIK: Thank you.

MR. VIVIAN: The other thing I would say I'm concerned about is that United may be too quick to deny, and that can cause a lot of angst. So I would be concerned about that.

MS. ORLOWSKI: I just wanted to point out that they're correcting their mistakes. They recognized in the autumn that they were denying or terminating people and reducing hours, and they were

taking corrective measures. I appreciate when they take corrective measures without making me go to a fair hearing. That's better for everybody.

MR. VIVIAN: But it would be better if they didn't deny so easily.

MS. ORLOWSKI: Agreed.

MS. JACOBS: I'm Jennifer Langer Jacobs from Amerigroup. I just wanted to add on to a couple of the things you were saying. You talked about the continuing hours not being in place. It sounds like an implementation problem maybe of one of the MCOs. Certainly, if it's my MCO, I'd like to know. And then the letters that Gwen mentioned, one of the challenges that we run into is somebody writes a really nice letter, and then somebody else puts it into fifth grade level language, which is required. When you translate from the nice letter that somebody wrote to fifth grade level language some of the nuance and style and, frankly, clarity gets lost because you're trying to take it down several vocabulary levels.

I don't think we all use the same letter, but I'm wondering if it would be helpful for us to have that conversation about the best way to communicate this sort information at the reading level we have to communicate it. It's not something I've heard before,

so I'm just really interested in trying to get to the bottom of that.

MR. LUBITZ: Phil Lubitz. So the first thing I think we need to control when we're looking at complaints is the level of understanding of the recipient of the right to complain and the procedure to complain. That's really the first thing you have to understand, that there's equality across all the health plans about the recipient's understanding that they can complain before you really look at the number of complaints per organization.

MR. MANGER: Joe Manger from Horizon NJ Health. Just a quick comment. The Office of Managed Health Care does have templates. And I know Horizon NJ Health is using them, but I know that they're under discussion after revisions for just the same reasons brought up because of continuation of the benefits change that just went into effect January 1, and also the recent issue with PCA not having the right to deny an appeal. So I know those are under review and I know we will continue those discussions. We're right with you. They're not always the clearest things, but unfortunately there's a lot of regulatory and statutory stuff that we have to put in.

DR. SPITALNIK: Thank you.

Also, we wanted to add an item to Valerie's report, on the HMO Performance Report.

MS. HARR: I have hard copies, and we'll make sure we send a link out to the report. We have it listed up here on the overhead.

We do an annual HMO Performance Report, so I have copies of the 2011 Report to share with everybody.

DR. SPITALNIK: Thank you very much.

Our next item: State Fiscal 2014 Budget update. And I'll turn to Vasyl Litkewycz, the Bureau of Budget and Accounting and, DMAHS.

(Mr. Vasyl Litkewycz provided an overview presentation of the proposed 2014 State Fiscal Year Budget).

DR. SPITALNIK: Thank you very much.

Any questions from the MAAC?

MS. COOGAN: So the savings, the $227 million, that will stay a part of the Medicaid budget?

MR. LITKEWYCZ: Yes. Our budget would have gone up, but we will be able to receive a federal match.

MS. COOGAN: Right. So that $227 million is in your total?

MR. LITKEWYCZ: Yes. Out of a $3.5 billion state budget.

MS. HARR: I just want to mention our Department of Human Services budget hearings, we have the Assembly budget hearing on April 16th and the Senate Budget and Appropriations Committee hearing on May 1st.

DR. SPITALNIK: Thank you.

Any questions from the public about the budget?

MS. JACOBS: Please forgive me if you said this, but the $159 million in trend, does that include long-term care?

MR. LITKEWYCZ: Actually, it does a little bit, a piece of it, but not the whole Managed Long Term Care Services ans Supports (MLTSS).

MS. JACOBS: The long-term care that's currently fee-for-service is in there?

MR. CASTRO: The $8.5 billion for Medicaid is just for the Department of Human Services (DHS). Do you have the total amount for all departments?

MR. LITKEWYCZ: I believe our federal claim annually is about $12 billion, so the full Medicaid program statewide would be in that $12 billion, state and federal. Probably a little bit above that now.

DR. SPITALNIK: Thank you very much. And we wish you well with the budget hearings.

Our next item is the implementation of the Affordable Care Act initiative. And we have John Guhl who part of CMS Region 2, and former Division of Medical Assistance and Health Services (DMAHS) director.

MR. GUHL: I'm John Guhl. I'm now with CMS. And we are now involved in the outreach and enrollment for the ACA. I would like to engage as many stakeholders to assist with the outreach and enrollment efforts for the Affordable Care Act as possible. So I have a couple of forms if anyone is interested, please fill them out. Have three of the same form. I'll put it in the back. Anyone interested, please fill it out, and we want to help you help us with our outreach and enrollment efforts. As Valerie mentioned, enrollment begins October 1, 2013 so we need as much stakeholder support in the efforts to enroll as many possible as possible.

Thanks for your time.

DR. SPITALNIK: Thank you.

We'll go to other elements of ACA, the Non-Billing Provider Enrollment, the Provider Rate Increase. Valerie Harr and Marcia Harrison is in the Office of Managed Care Finance and Fiscal Reform from DMAHS. So I'll turn to Valerie and Marcia.

MS. HARR: Section 6401 of the Affordable Care Act requires that as of January 1st all ordering and referring physicians and other professions providing services to Medicaid recipients must be enrolled as providers. In absence of active enrollment, the services ordered must be denied. And again, this applies to the fee-for-service population only.

In September 2012, I had a great team of staff working on this and they created a three-page abbreviated application form. It's called the FD20B. We mailed out outreach letters, including the application, by using the Department of Community Affairs information on active practitioners.

In October 2012 we put a notice up on the New Jersey MMIS website with a link to the application, and a beneficiary poster was later added.

In November 2012, letters were mailed out 74 different organizations and advocacy groups. In December 2012, all hospital letters were mailed. And again, the two newsletters, Volume 22 No. 19 and Volume 22 No. 20 were issued in December. One went to pharmaceutical service providers, and the other was to all other providers. We just learned recently that physician assistants must also be enrolled as

non-billing providers. So 2300 letters were mailed out by our fiscal agent to enroll those physician assistants.

In addition, we met with the New Jersey State Society of Physician Assistants on March 22, 2013 to reinforce and get their involvement in educating their membership on this issue. And a newsletter, Volume 23 No. 6, was sent in March 2013 titled "Recognizing Physician Assistants as Non-Billing Providers."

That is the status update of that particular issue.

DR. SPITALNIK: We'll turn to Marcia now around the provider rate increase. Marcia, thank you for joining us.

I should mention for the public that we post the PowerPoints that were shown at the meeting on the website, and that's how you can access them. Members have copies of the presentations.

(Ms. Marcia Harrison provided a presentation on the Provider Rate Increase under the ACA).

DR. SPITALNIK: Thank you so, Marcia, for leading us through a very complicated and clearly labor-intensive process.

Any questions from the MAAC. Hearing none,

any questions the public?

MR. PYLE: Thank you very much for a detailed and technical presentation.

As a father of man who has a psychiatric disability, I'm very concerned that the ACA has done a great social injustice to all who have psychiatric disabilities by not including psychiatrists and other non primary care providers in the rate increase from the current 37 percent of Medicare rate to 100 percent. I'm also concerned that this is only going to last for two years for the primary care providers.

So my question is then to maybe the Medicaid department. What is the State going to do to equalize the payments for psychiatrists that are not being covered by the federal top upgrade? And who is going to decide what these rates are going to be so that we, parents and family members who feel very strongly about this injustice, may I say, note to where we could direct our advocacy?

MS. HARR: In terms of the Affordable Care Act, you could direct your advocacy to CMS, those providers were excluded from this rate increase.

This leads me into the next topic of discussion, because as part of our movement to a managed behavior health system, we are doing a rate

analysis.

Actually, Ms. Fresolone, can you comment on the status of the rate study for providers?

MS. FRESOLONE: I'm not sure we can talk about who it's going to be yet, but there is an Request for Proposal (RFP) for an actuarial firm to look at the behavior health rates. There will be a contract to look at behavioral health services rates, including the psychiatric service. There's a whole list of our rates and we'll look at it through an actuarial firm. They'll be making some recommendations for rate balancing for on all our services.

MR. PYLE: I appreciate the direction to CMS. I'm interested in somebody in the State because I'm interested to see if the State will then do what is necessary, even if CMS is not.

DR. SPITALNIK: I think what Vicki Fresolone was describing is a State action. And may I ask that we wait until we discuss the Administrative Service Organization (ASO) under the CMW and engage the issue there.

MR. PYLE: Who is going to make decisions about rates? I appreciate that the consultant firm is going make the proposal, but who is going to be the final decider as to what those rates are going to be?

MS. HARR: We'll get the recommendation. It depends on the outcome, but certainly the recommendations will come to me as the Medicaid Director; Lynn Kovich, the Assistant Commissioner for Mental Health and Addictions. And we will meet with our Commissioner of the Department of Human Services. So that information and that process will be shared with you, but we haven't gotten that far. It would be the State making the determination. If there's a budget impact, then we need to go through our budget process, which then would be the Governor's Budget and the Legislature. If there's a fiscal impact in terms of the State requesting an additional appropriation, it would be handled through the annual budget process. But we have to see the outcome of that analysis. That's from the State side.

DR. SPITALNIK: Are there any other questions about the provider rate increase?

MR. SPIELBERG: Josh Spielberg from Legal Services of New Jersey.

First, I think this is a great and a very important initiative because increasing reimbursement rates leads to more providers and better care, and I think it's great that DMAHS is moving forward on this, but I think there is some urgency here, given that the

program is only for two years. And it sounds like there's some things between the Division and CMS that are still going forward I wondered if you could speak to that and what you think the deadlines are as to when current providers will actually be getting reimbursement, how you're going to move that forward?

And secondly, a part of this is really to increase provider participation. And I don't think you're going to get new providers until the reimbursements are actually flowing. But I'm wondering what the procedures are on that.

And then the other thing I would request is that at the next MAAC meeting that this be on the agenda again so we can get updates.

MS. HARR: CMS has our State Plan Amendments (SPAs) to review. SPAs need to be submitted before the last day of the quarter. So we did that. So that would have been March 31, 2013 Assuming it's approved, it would be retroactive to January 1, 2013. And those payments would be reprocessed back to January 1, 2013 so the providers would see the rates back to that day.

MR. SPIELBERG: But in terms of new providers, in terms of getting current reimbursement at the Medicare rate, which will be a concern both to existing providers and to new providers, when will that

take place?
MS. HARR: That's what we hope, that more providers will be willing to accept Medicaid. It would be upon their enrollment either into the managed care organizations network or in fee-for-service. So it wouldn't be until they were an active provider. It's something that we are discussing internally, is there something that the MAAC could do or members of the public can do to try to attract, through communications, more providers to accept Medicaid and get that word out about the provider rate increase?
MS. ROBERTS: Again, for us all to be consistent, if there could be something that you put together about that and then get it out to everybody on the MAAC as well as everyone who's in attendance here, I know I would be happy to distribute it, and I think other people would as well.
DR. SPITALNIK: Thank you.
Anything else about the rate increase at this point?
MR. PYLE: Can I ask a quick question? Does the rate increase apply to all who are coming into the Medicaid system? It doesn't apply only, let's say, to the newly eligibles?
MS. HARR: It applies to all Medicaid

providers serving all Medicaid Title 19 recipients, new or existing.
DR. SPITALNIK: Marcia, thank you so much, and we'll put this on the Agenda for our next meeting.
Our last topic is our Comprehensive Medicaid Waiver update. We're going to move the third item, Dual Diagnosis and Pervasive Developmental Disorder Pilot Updates to our June 2013 meeting.
And I'll turn to Valerie Harr for an update on the ASO and the Behavioral Health Home and also the Managed Long Term Services and Supports (MLTSS) update. I'll turn to Valerie.
MS. HARR: So unfortunately given our time constraint, I don't think I can take you back in time and get you through our whole CMW process. But I think, Dr. Spitalnik may address that in an orientation for the new MAAC membership. We can certainly make sure you understand the whole CMW.
As I mentioned, we have 90 percent of our Medicaid beneficiaries enrolled in one of four HMOs, with the exception of people with developmental disabilities. Currently, behavioral health is a carve-out. So mental health and substance abuse services are provided to those in managed care but on a fee-for-service basis. So there is fragmentation and

there is no coordination and no utilization management for behavioral health services in Medicaid in general. And I'm talking really about adults, because the children system has already tackled that and has a mature program. So as part of the CMW, we work with Medicaid and the Division of Mental Health and Addiction Services (DMHAS) to propose a contract to go out with an RFP to contract with an entity to provide that coordination, utilization management, and support for both of our agencies.
The RFP for that vendor has been drafted and is under review. And it's a coordination between DMHAS and the Medicaid agency. I would say these are still optimistic timeframes but RFPs need to go through Purchase and Property in many cases, and the Office of Management and Budget needs to approve it. It's not solely within my authority. So optimistically, the RFP or Request for Proposal, will be issued in summer 2013. We hope to award a vendor in late fall or winter 2013. We would go live after January 2014 because we will allow ourselves a 4 to 6 month readiness review to make sure that the State's organizations and systems, as well as the vendor and providers, are ready to move into this new system.
The ASO is non-risk. It's a managed

behavorial organization but it's financed in a way that is different from MCOs?
DR. SPITALNIK: Questions?
MS. HARR: We are looking to doing a pilot of a Behavioral Health Home for individuals with severe mental illness. So we have a concept paper that has been sent to CMS, and we will begin to have conversations with CMS. It will result with a formal statement amendment and the selection of a region to do a pilot of a Behavioral Health Home. And we're targeting individuals with severe mental illness where they are receiving ongoing behavioral health services, and we want to try to physical health and mental services onsite and co-located or at least have strong coordination with physical health. It's really an attempt to coordinate physical health and mental health and substance abuse services.
Now, Managed Long Term Services and Supports, we do have a Steering Committee that was established as part of the CMW for Managed Long Term Services and Supports. While there's tremendous opportunity for long-term savings to the state and federal government, as well as improved quality of life, there are a lot of start-up costs and there's a lot start-up and systems and implementation that has to

happen, and we have so many on-going priorities that we've taken a step back and said, how can we start Managed Long Term Services and Supports in a way that we can administratively handle and in a way that is financially doable?

What we are proposing to do is have a staged implementation for Managed Long Term Services and Supports, beginning with home and community-based services, individuals receiving long-term home and community-based services and moving that into managed care, effective January 2014. The major reason that we did that is because approximately 12,000 individuals, are already enrolled in an HMO for their acute care services. So this would be an expansion so that HMOs would be responsibile for their services and supports. And then we are proposing that six months following, July 2014, the managed care organizations would be responsible for the nursing home population, which is another 28,000. This is a partnership between the Medicaid agency and our Division of Aging Services.

So we still working through a lot of the details. We are drafting revised contract language, because it's in contract what the MCOs will be responsible for managing when we have a Managed Long Term Services and Supports program. We're looking at

our care management program for this population. We are developing a set of Frequently Asked Questions that I know the Steering Committee will be receiving and commenting on. Dr. Spitalnik, I would offer that the MAAC review those materials and provide feedback. In the documents, We try to include questions that providers would have, as well as consumers about this movement to MLTSS.

We were hoping people are able to age while in their homes, in the community and delay, not that they won't need it, but delay their need to move to a nursing home setting.

DR. SPITALNIK: Thank you so much.

Questions from the MAAC about either the ASO or MLTSS?

MS. EDELSTEIN: Very quickly, I would like as part of the MAAC to be able to review the FAQs. You had mentioned that that was possibility?

DR. SPITALNIK: Yes, we will.

MS. EDELSTEIN: And also the communications issue, I know we've talked about a little in the past, but I would love to see if we could review that information and have that on the agenda for the next meeting. Thank you.

DR. SPITALNIK: Other comments or questions

from the MAAC?

Hearing none, Gwen.

MS. ORLOWSKI: Gwen Orlowski again from Legal Services of New Jersey.

I know that there was an issue with any willing provider, especially with nursing home and assisting living. I'm wondering if there's been any decision on that? And then there are certain aspects of the CMW that are not necessarily tied, or maybe they are, to the implementation of Managed Long Term Services and Supports, specifically the Medically Needy piece. There are questions around people who have chronic mental illness who meet level of care, and there's a lot of confusion, I think, among elder law attorneys on the attestation that came out recently about people at 100 percent of poverty and below, specifically because when we read the CMW language itself, it seems to say there will be no penalty for transfers; and, the attestation is talking about attesting that you haven't made a transfer.

MS. HARR: Any willing provider is still under special consideration, so there's no decision there yet. And, certainly with the delay of the moving the nursing home population into managed care, we think we have some more time to continue the discussion about

the any willing provider issue, which pertains to the nursing home providers. The Medically Needy provision is tied to the launch of Managed Long Term Services and Supports. Know Kathy Mason is so committed to this that she has assigned somebody on her staff to make this their sole focus.

Do you want to expand upon that?

MS. MASON: On the Medically Needy 217 provision, the person will spend down, for lack of a better word, by paying the portion of the premium that the State pays to the MCO for the home and community-based care services. So we need the premium amount or the capitation amount determined before we can implement that new provision. But the person would pay that premium amount prior to actually being enrolled in that MCO and then they would become just like any other Medicaid provider and would be eligible for home and community-based services through that plan. So we're working on implementing that as soon after January as we can.

MS. ORLOWSKI: I think the way people understood is that the spend-down would be to three times the Social Security (SSI) level. What I'm hearing from you is the income spend-down, not the resource spend-down. It sounds like it's going to be

the capitation rate.

MS. MASON: They still have to have their assets down to the Medicaid income level. The hypothetical eligibility is based on the private pay nursing home rate of about $7,000 month. That will make you categorically eligible for Medicaid. Then your deduction from your income to get back down to Medicaid eligibility will be based on the capitation amount.

MS. ORLOWSKI: Thank you.

MS. HARR: On the attestation, just so everybody knows, that one of the concerns is the amount of time that it takes for applications to be reviewed and processed and approved with the County Welfare Agencies. So one of the things we thought we could do to try to expedite that is -- for applicants that have income less than 100 percent of property that are applying for institutional Medicaid, the likelihood that they transferred any assets is very small. So we said in our CMW proposal we would like to waive the five-year look-back period for someone who is applying for Medicaid benefits with income less than 100 percent property, we would take an attestation that they did not transfer assets during that period. To us, it's a program integrity issue. There must be a sampling and

a review of these cases. If during that process or some other process it is found that one of the individuals who attested that they had not transferred their assets is found to have done so, we are not waving that. There will be the normal course of process to resolve that issue. So again, we think the likelihood of that is very small. We don't think that's a huge risk for the state or federal government. It's not waiving the penalty. It's allowing for the self-attestation, but we have to do a post-audit and that will be something we report on. And CMS is eager to see what the results of this are in our CMW. I think it's a demonstration that we're really pleased about and eager to launch.

So, Gwen, number three, can you clarify your question.

MS. ORLOWSKI: There are people who need nursing facility level of care but they're being told under the Global Options (GO) Waiver that they're not in the target population because they have chronic mental illness. When you look at the GO Waiver that phrase is used in two different places. One is the CMS requirement, so if the person otherwise would need to be in a psychiatric hospital, the State can't divert them to a home and community-based placement for

historical reasons. This has to do with reimbursement rates and federal matches, etc. But, then also in the CMW itself, the State limits it and said people with chronic mental illness or developmental disabilities or intellectual disabilities can't be on the GO Waiver. However, I've been told that that will no longer be the case when we move to Managed Long Term Services and Supports, that there won't be a prohibition on getting Managed Long Term Services and Supports. So I have clients right now who absolutely meet level of care, who absolutely need services, recognized as such, but because they're in their own homes and they are unwilling to receive those services in a nursing home, are in their own homes without services.

MS. HARR: So in general, I'm going to say you're correct. We have home and community-based Waivers right now, and we very much see them as silos and some of them have slots. When we move to Managed Long Term Services and Supports, that silo approach goes away. But, there will be a requirement for an assessment to be done, a plan of care to be developed, but you would not have that restriction. If someone is financially eligible for Medicaid and meets the nursing home level of care and a plan of care is developed and it's determined that home and community-based placement

and services are appropriate, that's what we would do.

MS. MASON: And, the only thing I would add is that Behavioral Health is part MLTSS, so hopefully that will provide a more holistic approach to that population.

MS. HARR: So that hopefully will be one of our great successes and accomplishments when we move to Managed Long Term Services and Supports.

DR. SPITALNIK: Thank you. Thank you all. This was a both a very full meeting and highly technical meeting, and I thank everyone for our presentations and their forbearance.

(Review of the meeting conducted by Dr. Spitalnik.)

DR. SPITALNIK: Do I have a motion to adjourn?

MS. COOGAN: Yes. Motion to adjourn.

MS. COYNE: Second.

DR. SPITALNIK: All those in favor.

MEMBERS: Aye.

DR. SPITALNIK: Any opposed?

Thank you all. We look to forward seeing you in June.

(Meeting adjourned at 12:30 p.m.)