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

June 11, 2014
10:00 a.m.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:

Deborah Spitalnik, PhD, Chair
Mary Coogan
Eileen Coyne
Theresa Edlestein
Jay Jimenez
Dennis Lafer
Dot Libman
Beverly Roberts
Sidney Whitman, DDS

MEMBERS EXCUSED:

Mary Bollwage
Sherl Brand
Wayne Vivian

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:

Mary Cruz	1199 SEIU
Evelyn Liebman	AARP
Juliana David	American Academy of Pediatrics, NJ Chapter
Michele Jaker	Amerigroup
Matt Minnella	Association of New Jersey Chiropractors
Elena Graziosi	Autism New Jersey
Dean Roth	Berlin Consulting
Shabnam Salih	Camden Coalition
Doretha Howard	Centers for Medicare & Medicaid Services
Nicole McKnight	Centers for Medicare & Medicaid Services
Dominique Mathurin	Centers for Medicare & Medicaid Services
Mary-Catherine Bohan	Community Care Behavioral Health Organization
Kimberly Salomon	Community Health Law Project
Nicole Hernandez	Healthfirst
Karen Brodsky	Health Management Associates
Karen Clark	Horizon NJ Health
Lillie Evans	Horizon NJ Health
Len Kudgis	Horizon NJ Health
Joe Manger	Horizon NJ Health
John Covello	Independent Pharmacy Alliance
Carol Katz	Katz Government Affairs, LLC
Joshua Spielberg	Legal Service of New Jersey
Christine Fares Walley	LIFE St. Francis
Jill Viggiano	LIFE St. Francis
Kathy Powers	Matheny Medical and Educational Center
Melinda Martinson	Medical Society of New Jersey
Jerold Rothkoff	National Academy of Elder Law Attorneys, NJ Chapter
Stephanie Briody	National Academy of Elder Law Attorneys, NJ Chapter
Cathy Chin	NJ Association of LTC Pharmacy Providers, Inc
Debra Wentz	New Jersey Association of Mental Health & Addiction Agencies
Mary Abrams	New Jersey Association of Mental Health & Addiction Agencies
Maura Collinsgru	New Jersey Citizen Action

ATTENDEES:

Colleen Picklo	New Jersey Hospital Association
Ray Castro	New Jersey Policy Perspective
Sleina Haq	New Jersey Primary Care Association
Amanda Melillo	NJ Quality Institute
Karen Shablin	Optum, Inc.
Virginia Plaza	Otsuka America Pharmaceuticals, Inc.
Matthew D'Oria	PerformCare New Jersey
Alicia Kagan	Rothkoff Law Group
Mary Kay Roberts	Riker Danzig Scherer Hyland & Perretti, LLP
Steven McRae	Sequenom Laboratories
Peg Kinsell	Statewide Parent Advocacy Network
Kim Todd	The Innovations Collaborative
Julie Caliwan	The Innovations Collaborative
Zinke McGeady	Values Into Action of New Jersey
Susan Lennon	Warren County Aging & Disability Resource Connection
Lorraine Scheibener	Warren County Welfare Agency
John Kirchner	WellCare
Lisa Knowles	WellCare
Karen Kasick	NJ Div. Of Family Development
Alison Gibson	NJ Department of Health
Lowell Arye	NJ Department of Human Services
Martin Zanna	NJ Division of Aging Services
Felicia Wu	NJ Office of Management of Budget
James McCracken	NJ Office of the Ombudsman for the Institutional Elderly
Mark Moskovitz	NJ Office of the State Comptroller, Medicaid Fraud Division
Elizabeth Fortunato	NJ Division of Medical Assistance & Health Services
Thomas Lind	NJ Division of Medical Assistance & Health Services
Phyllis Melendez	NJ Division of Medical Assistance & Health Services

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DR. SPITALNIK: Good morning. My name is Deborah Spitalnik, and I'm the Chair of the Medical Assistance Advisory Council (MAAC). It's my pleasure to welcome you to this June 11th meeting. I will call this to order by starting with the statement of meeting notice.

Pursuant to New Jersey's Open Public Meetings Act, adequate notice of the schedule of quarterly meetings for calendar year 2014 of the Medical Assistance Advisory Committee was issued by the Department of Human Services. This public notice and invitation and attend these meetings was transmitted to the Medical Assistance Customer Centers and County Boards of Social Services for posting on November 1, 2013. It was posted on the NJ Department of Human Services (DHS) website on November 6, 2013. It was published in newspapers beginning on November 7th of 2013, the Atlantic City Press, the Bergen Record, the Camden Courier Post, the Newark Star Ledger, and the Trenton Times, as well as filed with the Office of the Secretary of State on November 20th and published in the New Jersey Federal Register on December 2, 2013.

Today, our agenda includes the approval of the Meeting Summary. There's a presentation on primary care provider reimbursement. Director Harr will give

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us a series of informational updates which are detailed on the agenda.

I also want to take this opportunity to thank Dr. Whittman for chairing our last meeting.

Let me start with introductions.

(MAAC Members introduce themselves.)

(Attendees introduce themselves.)

DR. SPITALNIK: Thank you all. As you can see, we always are delighted to have such a diverse group of stakeholders.

We will turn now to the review and approval of the Meeting Summary for April 11th.

Are there comments or corrections?

Do I have a motion to approve the Minutes?

Opposed?

Extensions?

The Summary for April 11th are accepted and approved. Thanks to Ms. Bradley and Phyllis Melendez and Dr. Whittman. Our first presentation for today is on the primary care provider reimbursement rates. And I think this is Stu Dubin's first time doing a presentation for us, so I'll turn to Valerie Harr to introduce Stu, and we'll proceed with the presentation. The slides will be projected. And, again, they will be posted on the website.

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MS. HARR: Thank you, Dr. Spitalnik.

The last meeting was the first time we had to announce emergency evacuation procedures. So we have to announce this at each meeting.

Upon hearing the fire alarm or an evacuation announcement, quickly leave the building via the nearest exit and go to Lamp Post No. 9 in the parking lot. Once there, you will report to me. I will check your name off the attendance sheet. Wait in your designated area for instructions from emergency response personnel. I wanted to tell you a little about the purpose of this presentation. We're calling this presentation a little bit of a myth buster. I think there is a lot of misinformation, anecdotes or myths about primary care reimbursement under Medicaid, and I think it started with one particular study where we certainly see some truth, but there's some flaws in the study. Other studies have come out and we've done our own analysis around physician reimbursement in New Jersey Medicaid.

Stu reports directly to me. Stu and I worked together in the Office of Management & Budget a long time ago. I recruited Stu into the Director's Office to do a number of things. Stu is really building a lot of meaningful data and dashboards for

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the Division to use. And also, he now has staff who produced the -- and you have all received copies -- this latest version of our Medicaid performance report, which really took the previous managed care organization (MCO) performance report and I think really took it to the next level and looked at all of the Division's operations and programs and through his leadership is really moving us toward more performance-based metrics. So when you see a lot of data on the slides that we do and the data analysis and the data reporting on the expansion enrollment that we do to the federal government, it is Stu and his team that are behind all of that.

I said, there's been the Health Affairs study around physician reimbursement out. We know that there's also a different reimbursement rate that we pay to Federally Qualified Health Centers (FQHCs) and we know studies have come out. Can you sort of pull it all together and synthesize for the MAAC and for the public. And so this is really the first debut of that effort to try to paint a fuller picture of our physician reimbursement.

So, I'll turn it over to Stu to go through the presentation.

MR. DUBIN: So good morning, everybody.

Thank you, Val, for that great introduction.

We're going to talk a little about provider reimbursement. And the Health Affairs article that started all of this and also talk about access to physicians for Medicaid recipients. And so I'm going walk through four studies that kind of incorporate both issues but really focus on the access issues. I look at access through four different lenses, use four different methodologies for study, use surveys, use raw data. And kind of go through here's a study, here's what they used, here's what these studies found.

(Presentation by Stu Dubin.)

DR. SPITALNIK: Thank you so much for both putting this information together and making it so accessible to all of us.

I will start with any questions of Stu from MAAC or discussion.

Beverly.

MS. ROBERTS: Thank you very much. Just a couple of questions that I have. This was physician data, and I'm wondering if you have or could look at dental, access to dental care and behavioral health for persons with developmental disabilities who receive those services from the MCO. I think that would be helpful.

Anecdotally, and I'm guessing Sid Whittman would second this. We hear about a lot of problems on dental care side with access. So I would really love to know maybe for future meetings.

MS. HARR: These weren't our studies. These were studies from, for example, Health Affairs and Rutgers, etc. -- this last slide was pulling our own data. We'll see what we can do. These were statistically valid academic studies, which is very different from us just pulling our data and doing analysis.

MS. ROBERTS: One of the things, again, anecdotally, that I and other advocates have heard of is networks where if you look at a list there are a lot of physicians, dentists listed. But then when a call is made to get care, they're told they're not taking new patients. So that's something that is a concern.

And so now my question based on the data that you've shown today, what should advocates do when they're hearing about somebody who is saying, "I tried to call, I called X number of doctors, and they're not taking new patients or I'm going to have to wait a long time to be seen?"

DR. SPITALNIK: I would direct that question to Director Harr.

MS. HARR: I think what we're trying to say is -- we're trying to present the data as best that we know it. If there are examples, you should call our Medicaid Hotline, which is 1-800-356-1561, and ask to be directed to the Office of Quality Assurance. And that's what we do. We advocate on behalf of our individuals. And if there's a problem with getting access, that's what we're there for.

I don't think we did see -- the data doesn't seem to support it and the experience that we see in our review of the networks and types of complaints that we get, we're not seeing huge volume. I'm sure there are and sometimes there's just misunderstanding and confusion, too. So that's when you should contact the Division of Medical Assistance and Health Services (DMAHS) and we would help the family member or the caregiver.

DR. SPITALNIK: Theresa.

MS. EDELSTEIN: Thanks for the presentation. Just a question. I don't know if you know off the top of your head. Did any of the studies look at time of day or day of the week in terms of accessing primary care physician offices? Evenings and weekends are notorious for being the time when Medicaid and other insured beneficiaries want to access their primary care

offices. So was there any independent analysis of time of day and day of the week.

MR. DUBIN: In these four studies there was no access. These were just kind of asking general questions. "Could you get an appointment? Could you find a doctor?"

MS. EDELSTEIN: That's when we see emergency room (ER) use at its highest, at the times when it's less typical that you can access the physicians office.

MS. HARR: That's actually not our experience. We are finding that people are accessing the emergency department (ED) even during the normal weekday, you would think the physician office would be open. And also we saw that with people utilizing the ED, it's not that they were using the DR instead of a physician office; they're using both.

MR. DUBIN: And there are studies that have looked at time of day.

MR. LAFER: I think this is great that you put this together this way and informed all of us. Congratulations.

I wanted to talk a little bit about the rate increase. Because the physician primary rate increase, would you have expected a change in the demand on these type of services?

MS. HARR: If you're asking me, I would say no. I think the public at large -- and I shouldn't speak for the Center for Medicare & Medicaid Services (CMS), but I think the expectation was yes. But we did a rate increase several years ago for pediatrics and did not see an increase in the number of participating providers or utilization.

So I think that I had said it's maybe perhaps still too early to tell. But when I look at this chart, I can't draw any conclusions from it. There's a bump-up in January and a little bump-up in October.

MR. LAFER: So with the increase, do we have data to show were there are now new physicians in the market becoming primary care providers (PCPs) that are willing to take Medicaid that weren't willing to take it prior to the increase? Do we have any sense of that?

MR. DUBIN: We started to do a look at that before we ran out of time. So, yes, we are taking a look at that.

MR. LAFER: Because I was hoping there would be an increase because I guess there would be more impetus to try to continue with these rate increases. I guess it's going to be terminating next year.

MS. HARR: I believe there were discussions at the federal level -- something proposed in the President's budget to continue it, but I haven't heard the status of that. I haven't seen a report from CMS where they analyzed or drawn any conclusions yet nationally.

MR. WHITTMAN: I was in a meeting in Washington, DC the last couple of days, and one of the things that was discussed was dentistry -- I can only speak for dentistry -- that when there were rate increases, the provider participation went way up. And CMS was willing to admit that.

DR. SPITALNIK: Other comments or questions from MAAC?

We are open for brief comments or questions from the public. I'll ask you to stand and identify yourself and try to project.

Ray.

MR. CASTRO: Ray Castro, New Jersey Policy Prospective.

It was a great overview of the studies. I guess the challenge is they were all done before the expansion. And we're seeing, as you know, a huge number of people enrolling, and they don't take into account the reduction that will likely take place next

year. I'm just wondering if someone can explain what does that mean to a typical physician in managed care? How is their salary affected? Have there been negotiations with the MCOs? Are the MCOs planning to mitigate some of the decrease in the reimbursements?

DR. SPITALNIK: Can you clarify? We're not clear on what you're asking, Ray.

MR. CASTRO: I'm trying to find out what the likely impact is going to be when the reimbursement is cut next January. As I understand, it will be reduced by about half, right, for primary care physicians? And I'm just trying to find out what does that mean to a typical primary care physician. How is that going to be translated at the MCO level?

MS. HARR: The Managed Care Organizations, as I understand it, maintain their reimbursement rates the same. So that when the primary care bump-up ends, the rate that's in place under contract will continue. It will be the supplement payments that the physician will not be receiving. MR. CASTRO: Right. So how much would that be for a typical physician? How much of a reduction would they receive? We know the reimbursement rates, I understand, is going to be reduced to about half. But I don't know what would that translate in terms of those physicians. I'm

trying to figure out what the consequence of this might be in January in a real sense.

MS. HARR: I don't know that I have a percentage, but if you go to the slide in terms of the total dollars, you can see the total dollars. I think we said annually it is $100 million annually across the State, managed care and fee-for-service (FFS).

MR. CASTRO: Have the MCOs expressed any concerns about it? Do they have any plans to address this issue in any way, in terms of trying to adjust to this? Is the assumption that there's not going to be any impact so we're just going to continue? Or, do we have a contingency plan here?

MS. HARR: I would say they have the network providers prior to the increase, so the same providers that were in network prior to the increase got the supplemental payment. And so far, as we said, we haven't seen that there was a greater number of physicians coming to participate in Medicaid because of the increase. And I would say that managed care organizations had network adequacy before the increase, during the increase, and they will have to have it after the increase. So if it's the same group of providers, I don't know -- I'm not thinking that if a provider is willing to be in network and accept

reimbursement rates with the plans before the increase why that would change if the increase didn't continue.

DR. SPITALNIK: Josh.

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

Thank you for the presentation. I think it is very helpful to get data to analyze what's going on. A couple of questions. The first is when you were talking about the Health Affairs study, you said they looked at fee-for-service rates, not MCO reimbursement rates. What kind of data do we have on how those rates compare?

MR. DUBIN: There are a couple of different metrics that we use to look at this. One is a by procedure code, how much are actual reimbursements. We have our fee-for-service claims. We get the encounter transactions from the MCOs. We look at what they paid for their services. When you look at it by that measure, the MCOs are slightly better. They reimburse better than fee-for-service slightly. It depends on the code. From just about even to almost two times as much for certain codes. When you look at it on a per visit level, I'm going to bill a number of different procedure codes. Patient, date of service, provider combination; that works out to about even. It's

similar, but we're still refining how we're doing that visit metric and also the procedure code. We want to make sure we're getting the right data.

MR. SPIELBERG: So if you look at it per visit, you're saying the fee-for-service rates are about even?

MR. DUBIN: What we've looked at so far, yes.

DR. SPITALNIK: I heard the word preliminary, so I would caution the inclusion of that.

MR. SPIELBERG: The second question has to do with the last table in terms of the effect of the primary care rate increase. So as I understand it, from the primary care rate increase, the physicians didn't actually see any money because of getting all the administrative requirements done until late in 2013. I'm not sure when that was. I'm thinking like October or November. Whether you took that into account. And then secondly, there is this issue that physicians are worried about getting into a program now even though there are increased rates when they may drop down in December again and whether there's a way to take that into account when you study this.

MS. HARR: I would have to check. I'm not sure of the timing. There was a delay in getting the

payments out, and then it went back retroactively. But I think that we're both agreeing that additional time is needed. I don't think I can draw any conclusions based on that chart. You pointed to one reason. In terms of there could be a lag because of the delay in the payments.

A lot of times we when we talk reimbursement, people are looking at a particular code. It's not often that a provider bills us with one code. There are multiple codes on a claim. So we look at reimbursement for the visit, which is a very different figure. We'll also looking at reimbursement varies by provider type. So we pay for physician and primary care visits in hospital outpatient settings and federally qualified health centers (FQHCs). And the reimbursement rates are different than just the private practice. So I think there's more to come on that as we continue to analyze that data. But we reimburse federally qualified health centers for physician visit on average $139 per visit.

DR. SPITALNIK: Other questions.

MS. MARTINSON: I'm Melinda Martinson, and I'm from the Medical Society of New Jersey. The physicians would be very interested in a comparison between fee-for-service rates and managed care rates to

have a benchmark on that. I don't think that we really have good information on that. So that would be a request. And I understand what you're saying about the episode of care. And if we could just compare apples to apples on that, that would be fine, too.

MS. HARR: I guess maybe if you could clarify what you would be interested in seeing, because your providers would know. They can see the Medicaid fee schedule and then they know what they're under contract for.

MS. MARTINSON: That's right. And what we hear anecdotally, which we would like to be able to verify, is that a lot of the managed care rates are not better or significantly better than the fee-for-service rates. So in a transparent world, we would just like to know where are they pegging. Are they pegging higher than fee-for-service or not? Because fee-for-service rates are very low nationally. So it sounds like you're going to look at that.

MS. HARR: Yes.

DR. SPITALNIK: Thank you.

Thank you so much. We appreciate it.

We'll now move to a series of informational updates. And I will leave it to you to decide whether you would like to go through all of them and then take

questions or whether you will take questions topic by topic. And Director Harr will provide most of these, but also Dr. Lind and Deputy Commissioner Arye.

MS. HARR: I'll start with the latest expansion enrollment figures. Again, we started taking applications for the Medicaid expansion to childless adults and couples without dependent children in October with coverage beginning in January.

(Presentation of NJ FamilyCare Expansion Enrollment by Director Harr.)

MS. HARR: I will take questions on the Medicaid expansion before moving to the next item.

DR. SPITALNIK: Questions from the MAAC? Questions from stakeholders?

MS. COLLINS: I'm Mara Collins from the New Jersey Citizen Action. Thank you for both presentations. They were very helpful.

Valerie, the question regarding the backlog, we understand it varies by counties. We also experience similar information. What's more concerning or as concerning right now, and this is particular NJ FamilyCare applications, is that we are hearing from our partners on the ground that determinations for New Jersey FamilyCare, individuals are being denied improperly. I did segment that information. This is

in addition to what's happening at HealthCare.gov and they have their own issues going on.

So I wanted to know is there any monitoring going on of that and what is the resolution? Is there a glitch somewhere that you're aware of and how we can address that? Because it seems to be an emerging pattern that's happening quickly.

MS. HARR: No, I'm not aware of a glitch. And if there are applications -- again, I don't know what in terms of if it's county welfare agency (CWA) with respect to Xerox and the health benefits coordinator, every one of those applications goes through quality control and then the state reviews them on top of that before there's a final determination.

They have a right to appeal. Josh brought to our attention some problems with a letter that we have since corrected. But if there's a denial, they have a right to appeal that denial. That's what I would encourage anybody to do if they think that it was not a correct determination. So I would say also, give me specific examples because I'm not aware of there being a systemic problem that denials are happening inappropriately.

MR. ROTHKOFF: Jerry Rothkoff. Has the State concluded on what the status of Medicaid estate

recovery for expansion eligible individuals?

MS. HARR: I can get back with particular detail, but it's my understanding, based on CMS guidance that the State recovery process applies to all Medicaid eligible individuals. I don't know. If somebody from CMS wants to comment on that if that's correct or otherwise, I'll get back to you and I'll check with my legal folks, but that's my understanding.

MR. ROTHKOFF: But CMS also issued directives, a request to each individual expansion state to not apply Medicaid estate recovery to expansion eligible individuals, which I'm sure the state is familiar with.

MS. HARR: I'm not prepared to discuss that topic today. If you want to give me your contact information afterwards, and I could respond to it at the next MAAC.

MS. WALLEY: Christine Walley, LIFE St. Frances. Could you just give me a little more clarification on the waiver for redeterminations? When did that become effective? And does that mean that these folks will not be receiving redetermination requests from now to the end of year?

MS. HARR: Yes. I have to confirm because we had a waiver redetermination initially from January

through March, and then it was continued -- I believe it was then approved April through December. So there are some county welfare agencies that want to do the redeterminations because they're concerned that -- if they don't have a backlog and they're able to do redeterminations, they would like to get them done. Otherwise, they're creating a workload for themselves in the future. So I would say that's a business decision that the county welfare agencies can decide upon. But I know those that are having the backlog were very happy to hear that they did not have to do the redetermination. So some counties may still do it and some won't. I'm pretty sure the health benefits coordinator is not doing redeterminations. That waiver does say that once we're caught up with all of the applications we would reinstate redeterminations prior to December, if we're caught up.

MS. WALLEY: Thank you.

DR. SPITALNIK: Josh.

MR. SPIELBERG: First a comment. Those are great numbers in terms of enrollment, and I think you and the Division ought to be congratulated in enrolling so many new people in New Jersey Medicaid. It really has been a success in that regard, and I think it's made a difference in people's lives, so thanks you for

the job your doing on that.

The question I have goes to the question about those denials. And the question is whether you are keeping or you have data on how many denials have taken place, particularly at the state eligibility determination agency Xerox. Do you have data on that?

MR. DUBIN: I don't know if I have it with me.

MS. HARR: We have it for the determinations that are occurring at the vendor. I don't have it at the county welfare agencies. Although we just added -- they have tool that they use to pull down the online applications. And we've asked them to go in and use a drop-down menu to tell us the disposition of each of those. We just launched that on Friday, so that I have real data from the status of applications at the county welfare agencies, if they're duplicates, if the people were denied, if it's still pending.

MR. DUBIN: We have it, but I didn't bring the detail through the most recent month with me.

MS. HARR: So we'll add it to the agenda for the next meeting to report on the denials at Xerox and the counties if they report it.

MS. LIEBMAN: Hi. Evelyn Liebman from AARP.

I echo Josh's remarks in terms of

congratulating the Division for the extremely positive numbers and expanding access to health care.

I have a question about the backlogs. Can you shed some light on where these backlogs are at the county level? Is every county experiencing a backlog? Which ones have the worst problem, if you will?

It would be good for us to be able to work with consumers and identify the most efficient way for them to access the system. We have some information on Camden, but we don't really know any of the other counties.

Overall, do you know what the backlog is?

MS. HARR: Yes and no, because not all counties are giving me the information. So I would say a half to two-thirds are reporting their data to us weekly. I think it was 50,000 applications statewide among the counties that reported it to me.

For the most part, I'm going to over-generalize, but I would say backlogs exist in the more urban areas, where's there's greater volume. I know Salem reported zero. So I don't think that would be any surprise. I meet with the county welfare agency directors on the first Friday of every month. I think there are two reasons. One is volume. It's just a great amount of volume, and they're short-staffed. I

think it's forcing them to rethink their business flow, business processes. So Camden's really been very good about thinking about hiring some temporary staff to start looking at -- just even checking to see if it is a duplicate application and rethinking how they're processing applications. And they'll say, too, they don't have the tools or technology.

DR. SPITALNIK: Evelyn, were you asking, in a sense, an advocacy question about whether at the grassroots level you should people move to HealthCare.gov so as not to get engaged in the backlog?

MS. LIEBMAN: Yes.

DR. SPITALNIK: And I think that is one of the things we talked about over time, which I think your question illustrates, is part of the reason that we all gather is so that in people's constituent roles they can take this information forward. So that maybe this dictates an advocacy strategy around help supporting people to use HealthCare.gov and avoid compounding the backlog and also get themselves covered more quickly. Thank you for that.

Yes?

MS. MELILLO: I'm Amanda Melillo from the New Jersey Health Care Quality Institute.

Kind of similar questions. Rather than

where the denials are, I was wondering for the newly eligible adults, the 175,000 enrollee number, could we get that by county?

MS. HARR: Yes. We have what are called public enrollment statistics. It's by county. It is on the Department's website.

MS. MELILLO: Is that just for the expansion population?

MS. HARR: It's broken down by category. And, yes, you would see it for the expansion population.

MS. MELILLO: Thank you.

DR. SPITALNIK: Thank you very much.

Yes?

MS. LENNON: My name is Susan Lennon. I'm from Warren County. I wonder if we could get -- and it relates to all of the Medicaid programs, an update on the system database. Can you give us an update on the status of that rollout. We've been hearing about it for a good 10 years or so. It's critical to all the programs.

MS. HARR: Yes. I'm trying to think about how to answer that. We have a contract with a vendor to build a statewide eligibility determination system for all of the Medicaid programs and all of the social

services and economic programs supported by the Division of Family Development for the 21 county welfare agencies.

Frankly, the passage of the Affordable Care Act put a monkey wrench in the rollout of that system, so we changed course to try to get the Medicaid pieces off the ground. But I think I reported previously that there were a number of defects found when testing the system, and we have not been able to launch the functionality to be able to connect to the Federal Marketplace or to process eligibility determinations.

So there are, at a very high level, lots of ongoing meetings, discussions. We have a quality review board, a monitoring board, that meets with the vendor. Jeanette Page-Hawkins, the Director of the Division of Family Development, and I are co-sponsors and run all of those meetings. So we are, again, back at looking at a proposed schedule, a new proposed schedule from the vendor. It is under review. And we are meeting. We're doing a half day with them on Tuesday to drill down and make sure we understand the assumptions and what it's going to take to meet the milestones in that schedule. So I can't give you new dates. It's not an approved scheduled. I hope at the next meeting that I will be able to give you some new

dates. But it's active, we're dedicated to it, both divisions and the department are fully engaged.

One of the things that we have to do is go through a security assessment before we're able to connect to the federal hub. And that security assessment is being conducted as we speak.

So there are lots of pieces, there are lots of system testing, interface testing with our other business partners, so the work is ongoing. I don't have dates for you, but it is still moving, with a lot of pressure being applied for us to get it off the ground. But the first goal would be to get account transfers launched so that we can communicate back and forth with the Federal Marketplace. So that's our first milestone that we want to achieve in very short order.

DR. SPITALNIK: Thank you. We'll put that on the agenda for an update for our next meeting. Thank you.

MR. ROTH: Hi, Dean Roth.

Valerie, just a follow-up. Is that last sentence you said, is that actually going to be within the Consolidated Assistance System (CASS) framework, the connection to the hub?

MS. HARR: Yes, within the CASS framework.

DR. SPITALNIK: Theresa.

MS. EDELSTEIN: I'm sorry to go back to a previous issue. I just want to go back to the redetermination issue to make sure I understood what you said.

What I think I heard you say was it's a county specific decision based on their backlog whether or not they do redeterminations; is that right?

MS. HARR: That's right.

MS. EDELSTEIN: So I guess just looking at it from a provider and beneficiary point of view, or trying to anyway, it seems like it would be confusing because if you don't know that your county does or doesn't have the backlog or what the backlog is and how they're making the decision, you don't know what to anticipate, if you're already serving a beneficiary or if you are the beneficiary.

I understand the problem it creates if you just don't do redeterminations for a period of time and then you face the music at some point. But I'm just concerned about the confusion. I mean, for a Program for All Inclusive Care (PACE) provider, Chris was the one who raised the question earlier, how do they know whether someone who may have a redetermination coming up is going to have it done or not have it done?

MS. HARR: Essentially, I would say nothing changes. A person will maintain their eligibility. Normally, what happens is the county is outreaching or notifying the member to come in or sending them a prefilled application if it's the vendor or just requiring them to come in. And that wouldn't happen. I'm not sure that I see there would be confusion. The person is still -- their Medicaid eligibility is still active. It's a plastic identification card. There's no term date on it. The provider swipes it. They're still going to have active eligibility.

MS. EDELSTEIN: Maybe we can talk offline and just try to figure out why for some it may provide some confusion. I mean, I think in the PACE environment in particular it may be a little difficult because you won't know which are, which aren't, and somebody may slip through the cracks inadvertently as a result. But let's take it offline.

MS. HARR: Okay. I'm going to move the next agenda item. I'm going to apologize in advance. I think because it's a very legal, technical issue, I'm really just going to read to you what I have. The request came from one of the members of the MAAC to provide some better understanding or explanation of a Medicaid Director letter or state official letter that

was recently provided to states from CMS. It's the United States v. Windsor Court Decision. It's CMS State Medicaid Director No. 14-005. It's US v. Windsor and non-MAGI populations.

(Presentation of United States v. Windsor court decision by Ms. Harr.)

DR. SPITALNIK: Thank you.

Any questions from the MAAC?

Any questions from stakeholders?

Thank you very much. And we will put that on our agenda for another time in terms of whether the determination has been made.

MS. HARR: This will be brief. I think we had shared -- Carol Grant was here to speak before that we're working on a personal care assistant (PCA) assessment tool that will be used for both personal care assistant services, state plan services, as well as those provided for Managed Long Term Services and Supports (MLTSS). We have the tool. Carol and Maribeth Robenolt went through some of the sections of the tool and then we said we were going into a testing period with our managed care organizations using the tool. So we did that. And what we found in that test period is that there is a lot of variation. So we are utilizing technical assistance resources from the

Center For Health Care Strategies (CHCS). We met last week to try to look at what we have received in terms of the assessments. I'm going to give you some examples. Just simple math errors. And I think there is definitely some misunderstanding of the PCA benefit. And so we think that there definitely needs to be an improvement to the instructions, some additional training that would need to occur. So we were continuing to do our analysis and work with CHCS to look at the PCA benefit as a whole, as well as this universal assessment that we will be launching.

So we we're not launching the new assessment tool yet until we are able to really close out and further analyze some of the outstanding issues with what we've seen with the assessments that we've received from the health benefits.

DR. SPITALNIK: Thank you.

Questions or comments about the PCA tool?

Questions or comments from the stakeholders?

Evelyn.

MS. LIEBMAN: Do you have some thoughts about when you might be ready to roll it out?

MS. HARR: I would really still like it to be September. We're meeting internally again in July. We plan to meet again with the plans on this subject in

August. Again, I'd like to have it in September. But I've been around long enough to know that there's always some other issue that surfaces.

DR. SPITALNIK: Yes? I'm sorry, we can't hear you, Susan.

SUSAN: Just a question. Regarding the PCA assessment tool -- well, two parts to the question. One, do you envision incorporating that into the New Jersey Choice MLTSS assessment? And two, if a person needs a personal care assistant, usually it's not a temporary thing and they probably need long-term support services. And I'm just wondering why have we separated the tool out?

MS. HARR: PCA is a state plan benefit, so it's available if it's medically necessary for any Medicaid recipient. And very often it could be time limited. I think you can say it is also a critical service for MLTSS and it will be incorporated into the New Jersey Choice assessment tool. It will be the same tool, but we will have people that will utilize the PCA benefit that will not meet nursing facility level of care too.

SUSAN: Thank you very much.

DR. SPITALNIK: Thank you.

We're going to turn to Dr. Thomas Lind to

talk about provider credentialing.

Dr. Lind.

DR. LIND: Good morning. I'd like to talk to you today about the work of the Credentialing Task Force and I'd like to keep the discussion as linear as possible, so I would like to talk about what we've done, what we're doing, and where we're going.

(Dr. Lind conducts a presentation on Provider Credentialing).

DR. SPITALNIK: Thank you so much.

I'll raise one question which might be a question more related to the next presentation. But has there been some consideration of creating a preferred provider network for people with developmental disabilities and co-occurring mental health issues and how would the basic credentialing process be included in the Administrative Services Organization (ASO) specifications?

DR. LIND: I would expect that there's some overlap with the medical and the behavioral health elements of this.

DR. SPITALNIK: I'm not sure they're the non-traditional providers, but rather traditional providers with a specific expertise. So it may be a language issue of the basic credentialing for

participation and then how it's interpreted as part of the ASO.

DR. SPITALNIK: I think there's important meaning of non-traditional providers here that we want to honor. These might be traditional behavioral health providers but with a different kind of expertise. And it may be analogous to how you manage the substance abuse credentialing within that. So I may be jumping the gun, but it intersects --

DR. LIND: I think that makes sense. And actually, probably a better title would be miscellaneous providers because that more closely addresses it. We've actually already discussed that. There's going to be some that are just going to come from all different angles we were going to incorporate at the end.

DR. SPITALNIK: Thank you.

Other questions?

MS. ROBERTS: Thank you very much for the work that you've put into this. The problem that I hear about over and over again is when a provider has been credentialed by one of the Medicaid MCOs and then wants to be credentialed by another one and has to go through all of the time and effort all over again. Is one of the components of this Task Force that if you've

been credentialed by one that that will give you --

DR. LIND: Yes. That's the aim of the Task Force.

MS. ROBERTS: An automatic expectation.

DR. LIND: Exactly. Instead of doing things in quint-duplicate, depending on how many plans we have, the goal is to do it once. That's why the plans are at the table with the State, because we all need to agree on whatever that single process is going to be. But that is the goal.

MS. ROBERTS: So at this point as of today, that is not going to occur as of right now?

DR. LIND: It's a work in progress.

MS. ROBERTS: It's what you're working on.

DR. LIND: Correct.

MS. ROBERTS: Okay. Thank you.

DR. LIND: Sure.

DR. SPITALNIK: Any comments or questions from the stakeholders?

MR. MANGER: Joe Manger from Horizon NJ Health. I want thank Dr. Lind for his leadership on this issue. I think all the plans have been in the room working with the State, along with the providers. And as Bev's raising, one of the complexities I know as health plans that we have is, for example, Horizon NJ

Health has commendable National Committee for Quality Assurance accreditation. We're all trying to work through this and that's why we're so glad the Medicaid Fraud Division and the NJ Department of Banking and Insurance are there because there's a lot of regulatory opportunities -- I don't want to use the word hurdles -- that we all have to overcome. But the leadership that is happening here is really groundbreaking in terms of understanding what the barriers are, and trying to address them. So it is taking a little longer. But I know in the outcome it's going to help all of us, both in administrative efficiency, provider satisfaction, no disruption of member care, and better outcomes. So we know it's a necessary step we have to go through right now. But thank you for what you're doing, Dr. Lind.

DR. LIND: Thank you, Joe.

DR. SPITALNIK: Thank you so much, Joe.

Any other?

We'll echo Joe's thanks, both for the work you're doing and for the presentation.

DR. LIND: Thank you.

MS. HARR: I'm going to move into the ASO/Managed Behavioral Health Organization (MBHO) update. Very brief, because I'd like to make sure I

dispel rumors. We are still moving forward with the ASO/MBHO program starting out with the Administrative Services Organization. So the Department is still moving forward with that initiative that is part of our Medicaid Comprehensive Waiver. We have a Request for Proposal (RFP) that has been drafted and it is going through the procurement process. So you'll see the different agencies that must review and approve RFP. And then ultimately, that RFP will be published posted by our Division of Purchase and Property in our Department of Treasury. There is then an evaluation period. There's also a window of time to allow for any appeals, should that happen. And then once the ASO vendor is selected, there's a four to six-month readiness review to ensure the vendor's ability to fulfill the contract obligations to ensure, again, the readiness to meet the requirements.

So potential bidders should note that Treasury has an electronic bid notification system. It's an optional e-mail subscription service that vendors may elect to use for notification about bids concerning commodities and/or services of interest. This electronic RFP notification service is explained and available on the web. I will give you the web address now. It's

www.nj.gov/treasury/purchase/erfpnotifications.shtml.

So that's all I have to say about the ASO/MBHO.

I'm going to take the luxury while we're thinking about RFPs -- I wanted to let you know that the Division will be releasing an RFP for a transportation broker. What we've decided to do is we're working with the Division of Purchase and Property using the same mechanism for them to post the RFP for a three-week public comment period. The comments must be submitted in writing. There will be a specific address that Purchase and Property will identify on their website to take public comment on the transportation RFP. I invite all of you to look at that RFP and to provide your comment because I know that there's been a lot of discussion around LogistiCare and transportation in the Medicaid program. So I encourage you to provide your comments. I don't know precisely when it will be posted. It is going through the approval process at Purchase and Property now, but I have asked that they expedite it to the extent possible. So I think it will be in the next few weeks that it gets posted for public comment.

DR. SPITALNIK: Thank you very much.

I'd like to call on Lowell Arye, the Deputy

Commissioner of the Department of Human Services to give us an update about Managed Long Term Services and Supports.

MR. ARYE: Thank you. Good afternoon. So what I've done is broken this information out into specific categories for people to know. Today is June 11th. Depending upon who you speak to in the State, we either have about 14 days or 19 days, because some people are using weekends. I work weekends so guess what, it's 19 days before we go live. So a lot of our staff are not here today. They're at conferences giving talks about MLTSS. They're also in the midst of working on final steps for MLTSS implementation.

(Mr. Arye conducted a presentation on Managed Long Term Services and Supports).

DR. SPITALNIK: Thanks very much, Lowell.

Any questions?

Beverly.

MS. ROBERTS: Thank you, Lowell, for that presentation.

I have a question about family members or other caregivers who might not be aware of any of the information that's been distributed. But I think that advocacy groups could forward some basic information. If we all had the same information maybe focussing on

care management, what care management is supposed to do to help people, and phone numbers for care management departments for each of the MLTSS programs that would be helpful. Is that something that could be distributed?

MR. ARYE: First, I've been very clear for several times -- in fact, I just reviewed the minutes from the last two meetings -- that it is the responsibility of all of the advocates in this room to do that. We have on our website. The Frequently Asked Questions (FAQs) that was reviewed here, all of that material is out. It should be put out to everyone. If you know people, give it to them.

MS. ROBERTS: Do we have phone numbers.

MR. ARYE: I believe there are phone numbers. If there are not, we will make sure that they are put in the FAQs.

MS. ROBERTS: The last time I looked, I didn't see MLTSS specific phone numbers.

MR. ARYE: If they are not, then we will make sure that we will put them in.

MS. ROBERTS: The reason I was asking specifically for care management -- I know about the FAQs, but I also know realistically that a lot of people are very busy. We can certainly distribute the

FAQs. What I was hoping was just in the same way that when there's a report and there's an executive summary and you distribute it, a lot of people read an executive summary of something rather than the full document. So in terms of broadly distributing something, if there was something comparable to an executive summary that emphasized what care management is, phone numbers, and then said, "And for more information see the FAQs," I think that would be easy for people to widely distribute.

MR. ARYE: What I can say to you is, as I said, we have 19 days. Whether or not we're going to be able to do that in 19 days, I don't know. We are trying to do those final things. The FAQs are written, and we've actually had our Public Affairs staff and a many others look at it to make sure that it's written properly, appropriately, and all those kinds of things.

MS. HARR: Let me jump in here. I would expect, and we can confirm, that the MCOs have handbooks. I would expect that their handbooks are changing or they have a separate handbook around people eligible for MLTSS, and their member handbook should be providing exactly the information that you're talking about.

So we can go back and confirm that the plans

would have member handbooks that should be exactly what you're saying, benefits available, here's how you access them, here's what a plan of care is, that type of thing. So let's see if that's, in fact, the case. And maybe see if there are components of those or if we can put them on our website a link to the handbooks instead of creating a new document. I think that probably exists.

MS. ROBERTS: And I think the advantage, too, if something can be done concisely -- handbooks are wonderful. To be very truthful, I have not read my one health care handbook. So while it is a very good thing, if there can also be something that highlights some things for people that are busy that aren't going to read the whole handbook. And then certainly, the handbook is a very good back-up for people to get all the details.

Thank you.

DR. SPITALNIK: Anything else?

Dennis.

MR. LAFER: Thank you. Excellent presentation.

You mentioned you have a number of metrics you will be utilizing to monitor. Is that something you can share with us, what those metrics are?

MS. HARR: Yes. So one is there's a quality strategy plan, that is, we shared some aspects of that early on with the MAAC. It went to CMS. They've asked questions. We're responding to questions. When that quality strategy plan is final, it's a public document. I want to make sure everybody has it. And there are lots of different reports and measures we'll have in there. Most of them are quarterly or annually. So Stu has been working on about a dozen more realtime metrics that we're going to have. And I think when we go -- as I was listening to Lowell, I'm thinking in our next MAAC, we're now going to change course in terms of reporting to you about actual implementation. So, yes, we can share those performance reports that Stu is developing. In the interim, we want to know immediately in the first month of when we go live how many people are in MLTSS, how many individuals meet nursing home (NF) level of care are we paying for MLTSS versus paying for nursing home care and to watch every month to see if we're achieving what's happening in terms of the composition of the population.

DR. SPITALNIK: Thank you.

Other things from MAAC?

There was a point back there.

MR. MCCRACKEN: Jim McCracken, New Jersey

Ombudsman for the Institutionalized Elderly.

Anticipating that with the rollout there may be a lot inquiries and the State may be overwhelmed, could you describe, Deputy Commissioner, the role that the Aging and Disabilities Resource Connection (ADRCs) will have for residents going into MLTSS and other services. It's my understanding that there's been a lot of extensive training with the ADRCs and they're also another very good resource on a county level that residents of those counties will be able to access.

MR. ARYE: That's a good point. Absolutely. The ADRCs will be doing, and have been trained on, options counseling and a variety of other things. Certainly for individuals who are just coming into the system, the ADRCs are going to be the folks who are the first line, our point of entry, as we say. So I think that that's also an excellent point.

I think when it comes to glitches in the way in which things happen, I think we have provider hotlines, and the like, at the state level, which are actually listed on our website. But certainly the ADRCs will be the ones who will be talking through some of those front-line issues.

Thank you.

DR. SPITALNIK: Josh.

MR. SPIELBERG: Thank you, Lowell, for that very thorough presentation. I have two related questions. So you talked about a training and that you have created subcategories of providers. And so I wanted to know what those subcategories were. And then secondly, you talked about how you're requiring documentation from the MCOs about adequate provider networks. So in terms of provider networks, have you developed standards? Or, what are you looking for in terms of adequate provider networks?

MR. ARYE: We have said to everyone all along, the MAAC as well the Steering Committee, that there are no national standards. CMS has given us little guidance on it.

MS. HARR: A couple of weeks ago we had a call with the State of South Carolina because there was a provider in New Jersey who said South Carolina had developed community-based standards. We had the call with South Carolina. They don't have the standards yet. They're meeting with their provider groups, in particular PCA providers. They're going through a process with their PCA providers right now, this month, and promised to send us the results of their work in South Carolina around any network standards they developed in community-based services.

MR. ARYE: So right now, it's two providers per county, which is our current standard. And we'll go from there.

With regard to your first question, we had subcommittees for the nursing homes (NF), assisted living facilities (ALs) and other traditional home and community-based (HCBS) -type services as well. The chairs of those groups were the leaders in those specific provider categories.

DR. SPITALNIK: Joe.

MR. MANGER: Joe Manger from Horizon.

I know from Horizon's perspective and I'm sure with the other plans, the network issue is one of the most significant. We want to make sure it's adequate. And as Lowell has mentioned, there's two provider categories. For ones where the members go into the services, the great thing about MLTSS is that it's where the member is located. We have to have sufficient numbers. So if the member is in Mercer County today when MLTSS goes live, the contract requires me to have service to make sure the member gets care wherever she is. So it's not like a traditional primary care provider where the person is going to the office. The member may be in Bergen County. But if that servicer can service the whole

state, then that's what's permissible. So I just want to make sure we're all on the same page. And that's why we're suspecting all the other states are having the same issue, because you really can't come up with a standard as simple as a county boundary or a municipal boundary or a town boundary.

MR. ARYE: Unless there are other questions, I do have one other thing to say.

DR. SPITALNIK: Did you have something.

SPEAKER: Just a clarification. First of all thank you for all of your hard work. Clarification on the Miller Trusts. Are Miller Trusts for the community and does the Medically Needy population remain in the institution?

MS. HARR: I think Miller Trusts will be discussed for the next agenda for the October 6, 2014 MAAC meeting.

MR. ARYE: We're not prepared to have that conversation at this point.

DR. SPITALNIK: So that's a future agenda item and process.

Yes?

MS. BRODIGAN: Bethany Brodigan (phonetic). When you said there are no national standards for home and community-based services, are you talking about the

number of provider networks?

MR. ARYE: For MLTSS the network database.

MS. BRODIGAN: Are you addressing at all CMS's new regulations that define what constitutes home and community-based services?

MR. ARYE: What I can tell you is that those regulations were put forward in January. They are effective March 21st or 31st. I can't remember the exact date, but March. It's not currently in those regulations. It was required for an 1115 Waiver. However, we know that CMS would like to move forward on it. At this moment in time, we're not being required. It has to be done within a year. We are working on it. And that's actually one of my other hats. That is absolutely one of the things that we are working towards. We will be putting together a work group, an internal work group initially to go through it. And this would be an internal work group, not just within the Department, but also with our sister departments, especially the Department of Health because of licensing issues. We will also be then doing what we need to do for public notice and the like. But at this moment in time, as we move forward with MLTSS, it's not part of our 1115 Waiver requirements at this moment. And we are moving forward on MLTSS we'll then also then

focus on what needs to be done to comply with the regulations.

DR. SPITALNIK: Thank you.

Lowell, you had said you wanted to say something in closing?

MR. ARYE: I did, about PACE. Everybody is focused on MLTSS. We are very excited about it. As another managed care option, and this is included in the ADRCs, they know about it, it's in all options counseling. The PACE program continues to be a program that is viable. I think that's the most up-to-date numbers. We are continuing with it.

In August we will be sending out requests to the current PACE programs who are potential PACE organizations that currently have zip codes already in place from the prior years, and we will ask them to let us know within 30 to 45 days -- we haven't made that final determination -- as to whether or not they will continue with their expansion and are holding on to those zip codes or not. We will be doing an RFP specifically so that any other entities who wish to create a PACE program in those zip codes will have opportunity to do that. So even though we're talking about the MCOs, I'm going to say and I've been saying it all along and will continue to say it, PACE is

another option especially for dual eligibles. So that is something that I want to make sure that people understand.

DR. SPITALNIK: Thank you very much.

Yes?

SPEAKER: And thank you for all this hard work. It's mind boggling. Truly. I've lived through it with you, and just to hear everything that's going on, it makes me want to take a vacation.

I have several questions. But one thing in particular is of deep concern, I think, the non-traditional provider network, such as waiver providers who have been providing services in GO counties, they are going to continue to provide services under Global Options, right, at least to the new year, as MCOs take over services?

DR. SPITALNIK: What's your question. Is that the question?

SPEAKER: My question is they don't have associations that have been meeting with you and your professional associations, so they kind of -- they don't know where to go, who to bill, what to do. They don't have contracts, but they're out there providing services. So if there's a way I can help or my ADRC network to help the MCOs get connected to those

providers who are providing services who don't want to drop their consumers, I want to help them.

MR. ARYE: First of all, there is a continuity of care provision that has to continue. In addition, you can go to the website. There's links to the provider relations phone numbers for the MCOs if they haven't talked to the MCOs already about specific contracts with them, they should do so. I think that the MCOs have been reaching out, as much as I know, to all agencies that they know of to basically ensure that they have contracts in place. I think if there's not, they will probably set up -- I'm speaking for them -- single case agreements during that time period and as they discuss and come up with contracts. So I think they need to conduct outreach as well. It's not just the MCOs, but the providers need to reach out to the MCOs, and should be.

SPEAKER: One last question. Is there a standard for provider reimbursement in terms of a timeline?

MR. ARYE: What we have done is in the contract with the MCOs, there are specific provider groups that have a standard. There are also specific requirements by DOBI on other aspects of claims reimbursement, and the MCOs are required to go by those

standards for all services as well.

SPEAKER: For non-traditional providers.

MR. ARYE: For all service providers.

SPEAKER: Thank you.

DR. SPITALNIK: Thank you.

One more question.

SPEAKER: Just one quick question. I know right now any willing provider pertains to assisted living. Is that something that will continue?

MR. ARYE: There is a two-year period for nursing homes, assisted living, etc. That is what the providers themselves asked us for. That is what they're getting.

SPEAKER: So is there some sort of plan in place that if a person lives in assisted living and after the two years they're not able to contract, for whatever reason the MCO won't take them as a provider, how do you move that person?

MR. ARYE: I appreciate the question. What I can tell you is that we don't need to think about that until June 30, 2016. I think we agreed to have the conversation prior to that we can deal with some of this.

DR. SPITALNIK: We appreciate the question.

SPEAKER: The people who are living in ALs

obviously are worried.

DR. SPITALNIK: Right. And I know that the MCOs are thinking about that very actively.

So thank you, Lowell. Our best wishes. Thank you for the presentation.

Before I call for agenda items for next time and review what we've identified, a couple of things that I just want to mention and really echo the congratulations and the admiration that's been expressed by both the MAAC and members of the stakeholder audience about the accomplishments around enrollment.

(Applause.)

DR. SPITALNIK: And as Josh, I think, pointed out so well, the difference this makes in people's lives. And so I think we really need to acknowledge that, celebrate, and thank you for that. And similarly, the credentialing process work where we've seen a concern that has been time-consuming, but is being addressed in a very systematic way.

Also, a point of reflection from the MAAC as the stakeholder input group for the Comprehensive Medicaid Waiver that is now coming into being and the enrollments that we're seeing, and the upcoming July 1st date for MLTSS. So I think it's worth that kind of

stock-taking as we move forward so quickly.

In addition to the kinds of updates we have about the progress of the program, the things that I've already noted for our next agenda are data on denials where they're coming from both geographically and any other information that we have about that; the progress on ironing out some of the challenges with the personal care assistant assessment tool; CASS; of course, continuing enrollment data; where the ASO process stands; MLTSS; and perhaps depending on where it is in process, more information about the State Plan Amendment related to Miller Trusts.

Other items? First from the MAAC, and then others.

MS. ROBERTS: Can we try again for an update on The Supports Program?

DR. SPITALNIK: Okay.

MS. ROBERTS: Thank you.

DR. SPITALNIK: And we will take these suggestions, including the update on The Supports Program.

Evelyn and then Ray, did you have something you wanted to suggest on the agenda?

MS. LIEBMAN: We were very exciting that regulations for Medicaid Accountable Care Organizations

were finalized, and so perhaps at the next MAAC meeting we can have an update on where we are how we're doing with that demonstration project.

DR. SPITALNIK: Thank you.

Ray.

MR. CASTRO: If we can get an update on the budget. The budget will have passed by then. And also, in particular, with respect to continuing the benefits that we have with the Medicaid expansion population.

DR. SPITALNIK: Thank you.

Other agenda items?

We meet again here on October 6th. It's a Monday, 10 o'clock, same time.

Do I hear a motion for adjournment.

MS. ROBERTS: Motion for adjournment.

DR. SPITALNIK: Roberts.

MR. WHITTMAN: Second.

DR. SPITALNIK: Second, Whittman.

We're adjourned. Have a wonderful summer, and thank you all.

(Proceeding concluded at 12:48 p.m.)

CERTIFICATION

I, Lisa C. Bradley, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate transcript of the proceedings as recorded.

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