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

April 13, 2015
10:12 a.m.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:

Deborah Spitalnik, PhD, Chair
Sherl Brand
Mary Coogan
Theresa Edlestein
Dennis Lafer
Dot Libman
Beverly Roberts
Wayne Vivian
Sidney Whitman, DDS

MEMBERS EXCUSED:

Mary Bollwage
Eileen C. Coyne

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:

Fred Hunter	
Mark Stephen	Alkernes
Daniel Keating	Alliance for the Betterment of Citizens with Disabilities
Dana Griffin	Altegra Health
Michelle Jaker	Amerigroup
Michael Brown	Bayada Home Health Care
Barbara Geiger-Parker	Brain Injury Alliance of New Jersey
Dean Roth	Burlin Consulting
Mary Catherine Bohan	Community Care Behavioral Health Organization
Shabnam Salih	Camden Coalition of Health Care Providers
Kimberly Salomon	Community Health Law Project
August Pozgay	Disability Rights NJ
Susan Saidel	Disability Rights NJ
John Indyk	Health Care Association of New Jersey
Dot Fahergy	Family Resource Network
Crystal McDonald	Faith in New Jersey
Karen Brodsky	Health Management Group
Chrissy Buteas	Home Care Association of NJ
Karen Clark	Horizon NJ Health
Lillie Evans	Horizon NJ Health
Joseph Manger	Horizon NJ Health
Ryan Larsen	IntelliRide
Philip Ladhaga	Johnson & Johnson
Gwen Orlowski	Justice in Aging
Carol Katz	Katz Government Affairs
Joshua Spielberg	Legal Services of New Jersey
Gwen Cleary	Lilly
Barbara Dunn	Magellan Health
Lori Abrams	MWW Group
Phillip Lubitz	NAMI of New Jersey
Sarah Kate Clark	New Jersey Family Planning League
Grace Egan	New Jersey Federation for Aging
Amanda Melillo	New Jersey Health Care Quality Institute
Raymond Castro	NJ Policy Perspective
Rebecca Barson	Planned Parenthood of Central & Greater Northern NJ
Matthew D'Oria	PerformCare New Jersey
Mary Kay Roberts	Riker Danzig Scherer Hyland & Perretti, LLP
Nicole Pratt	SPAN New Jersey
Beverly Roberts	The ARC of New Jersey

ATTENDEES:

Elisa Cohen	The Family Resource Network
Dot Faherty	Family Resources Center
James Lape	Trinitas Regional Medical Center
Virginia Plaza	V.M. Plaza Consulting
Zinke McGeady	Values Into Action of New Jersey
Lorraine Scheibener	Warren County Division of Temporary Assistance & Social Services
Debra Wentz	NJ Association of Mental Health and Addiction Agencies
Maura Collinsgru	NJ Citizen Action
Nicole McKnight	Centers for Medicare & Medicaid Services, Region II
Dominique Mathurin	Centers for Medicare & Medicaid Services, Region II
Ruby Goyal-Carkeek	Department of Children and Families
Elizabeth Manley	Department of Children and Families
Karen Kasick	Division of Family Development
Allison Gibson	NJ Department of Health
Lowell Arye	NJ Department of Human Services
Dawn Apgar	NJ Department of Human Services
Freida Phillips	NJ Department of Human Services
Carol Grant	NJ Division of Medical Assistance & Health Services
Roxanne Kennedy	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
Maribeth Robenolt	NJ Division of Medical Assistance & Health Services
Steven Tunney	NJ Division of Medical Assistance & Health Services
David Drescher	NJ Office of Legislative Services
James McCracken	NJ Office of the Ombudsman for the Institutional Elderly

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, the Chair of the Medical Assistance Advisory Committee (MAAC), and it's my pleasure to welcome the members of the MAAC, presenters, and members of the public. I will start with the required notice of New Jersey's Open Public Meetings Act that adequate notice of scheduled quarterly meetings for the calendar year of 2015 of the Medical Assistance Advisory Council was issued by the NJ Department of Human Services (DHS). The public notice and invitation to attend the 2015 meetings were transmitted to the Medical Assistance Customer Service Centers and County Boards of Social Services for posting on November 7, 2014, posted on the DHS website on November 14th, published in newspapers beginning on November 12th, including the Atlantic City Press, Bergen Record, Camden Courier Post, Newark Star Ledger and the Trenton Times. Notice was also filed with the Office of the Secretary of State and published in the New Jersey Federal Register.

I also need to let you know that as guests here we're required to announce the emergency evacuation procedure. Upon hearing the fire alarm or evacuation announcement, quickly leave the building via the nearest exit, go to Lamppost No. 9 in the large

public parking lot. Once there, you will report to either Valerie Harr or Phyllis Melendez who are the organizers of this meeting and who will check off your names. You are to wait in this designated area.

As is our protocol, the first thing I will do is ask members of the Medical Assistance Advisory Committee to introduce themselves. I will ask the members of the public to very quickly introduce themselves, not to raise questions or make comments at that time. We have been able to maintain a robust give-and-take between the appointed members and the members of the public unlike some councils which have very limited public comment, so when we do have comments and questions after presentations or announcements, I will ask members of the MAAC to ask their questions first. When they've finished with that, we will invite members of the public. We do maintain the right to limit discussion, not in the interest of cutting off dialog, but in the interest of this very robust agenda. But it is always our hope that we can continue to have this very enriching dialog.

So with that I will ask people to introduce themselves.

(Members of MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Thank you all. And again, we appreciate the interest and everyone's participation.

We have a series of agenda items, starting with the approval of the Minutes from the last meeting, presentations, and then a series of informational updates.

Let me at this point let people know that while there's a copy of the agenda available for people, both the Minutes and the slide decks are available on Medical Assistance Advisory Council website at: http://www.state.nj.us/humanservices/dmahs/boards/maac/.

So the task in front of us for members to review are the October 6, 2014 Minutes. And I will ask for any corrections, additions, or a motion of approval.

MR. LAFER: Motion to approve.

DR. SPITALNIK: So Dennis Lafer moved to approve.

MS. BRAND: Second.

DR. SPITALNIK: Second, Sherl Brand.

All those in favor.

MAAC MEMBERS: Aye.

DR. SPITALNIK: Any nays?

Abstentions?

The Minutes of October 6th are approved. Thank you.

And thank you again, as always, to Phyllis Melendez for her efforts in this regard and to our reporter, Lisa Bradley.

We'll now turn to an informational update about the supports program. And, it's my pleasure to introduce Elizabeth Shea. Liz is Assistant Commissioner of the New Jersey Division of Developmental Disabilities (DDD) in the Department of Human Services.

Liz will come up and join us at the podium. Thank you.

MS. SHEA: Good morning. Thanks for having me.

I just want to give sort of quick context for anyone is not familiar what The Supports Program is and then talk a little bit about where we sit today.

The Supports Program is a major DDD initiative that includes the Comprehensive Medicaid Waiver (CMW). It was designed to provide an enhanced

benefits package of community-based supports to individuals with development disabilities and their families - primarily for people living at home with their families, or on their own.

The major benefit of The Supports Program is that it's going allow us at DDD to put everyone in our system, everyone in the developmental disabilities(DD) Systems in one of two waivers. So we have a Community Care Waiver (CCW), which is a long-standing waiver that we've had, but The Supports Program will let us put everybody else that's not on that waiver onto a home and community-based services (HCBS) waiver which will allow us to draw down about an additional $100 million, which the Administration has committed to reinvesting back into The Program. In fact, in the design of the program, we're counting on that money to actually get us to the enhanced benefits package.

Again, to give a little bit of context about the two waivers: The CCW has been in existence since the mid-'80s, right now in order to get on that, we have a long waiting list for it. There are thousands of people on the waiting list for the Community Care waiver. So the only way an individual with a developmental disability can get on to that

waiver is to either come to the top of that waiting list, which could take some time; or, be declared an emergency. So there's also an institutional level of care requirement for the Community Care waiver. So there are some people in our system who wouldn't even need that level of care requirement.

With The Supports Program, on the other hand, anybody in the Development Disabilities System or the DDD system who meets our functional criteria, meets the level of care to be on The Supports Program. We also don't anticipate any waiting list.

That being said, we are just beginning to enroll people this July, and it's going to take us some time to get everyone in our current system enrolled. But once we do, they anticipate the way it will work is someone will come into the DDD system and go right directly onto The Supports Program without having to wait and be able to get the entire benefits package.

The services are pretty expansive. It includes a lot of services that we currently provide, the day habilitation, supported employment, respite, et cetera, although some higher budget amounts to actually purchase more of a service, I think is a major benefit to people. But we've also massively enhanced the

services that are going to be available to people. So we have career planning, prevocational training, therapies, which were not in our system before.

One thing of note on the therapies is that occupation therapy, speech therapy, and physical therapy are all services, as you probably all know, that are available now on the State Plan so people can already get them, but they can only get them for rehabilitative purposes. For both of our waiver programs, individuals would be able to purchase them for habilatative purposes, which is important in the developmental disability community, as well as for rehabilitative purpose if their State Plan services exhaust or run out.

So that's just the backdrop of what The Supports Program is and the intention behind it.

We are currently in the second phase of implementation of The Supports Program. While it was included sort of philosophically in the CMW, there was a lot of reform that had to happen to get us to the place we're at now. So the design of The Supports Program is based on other midline reforms happening at the same time. So, for example, one of the promises we made in the CMW is that we would stand The Supports Program up using a standardized assessment tool for all

people across the developmental disability system. That is now in place. We have the New Jersey Comprehensive Assessment Tool that's in place across our system. We will very soon be going back and, actually over the course of this summer, re-evaluate across our entire system according to the New Jersey Comprehensive Assessment Tool. That took us some time to put in place. It's now been operational since November 2014.

We also promised a standardized service plan. Historically, in DDD, we weren't necessarily known for standardizing a lot of things, so we had a variety of different assessments. At the time, we also had a variety of service plans. We now have one standardized system across the State, which is called an Individualized Service Plan, that everybody in our system will be using. And that's been operational since, actually, June of 2013, but we've been slowly rolling it out. Over the course of the next 12 to 18 months, everybody in our system will be in the new service planning process. So there's a real push on enabling people to have choice. We're switching our system in a way that we're going to have a support coordination model. We now have fifty-plus agencies that have already come on board and have been trained

12

in our system that will be providing care management so that people can take their budget and say I like, or don't like my care manager, my case manager, I'm going to, instead, say okay, this is isn't working, I'm going to go here.

That model, again, took us some time, and that's has been operational since the summer of 2013 as well, and we'll be slowly enrolling everyone into that.

Another thing that underlies being able to stand up The Supports Program, or get it fully implemented is that it's supposed to be a fee-for-service model (FFS), and that requires standardized rates. So we embarked on a 18-month long rate setting process, a grueling difficult rate setting process, which we completed and we now have drafted. Actually, this week a finalized version of our rates will be out. So we'll begin to be using final standardized rates in our system July 1st. Again, it will be rolled-out over time, over the course of the next year or so, but we finally do have rates to do that.

So that's kind of where we sit, as that's some of the main things we had to do. Major priorities for right now are to get us into the July 1

13

enrollment -- that's really our big push date right now, July 1st.

Our provider application just opened up, so we're really making a big push starting now to really recruit providers across the system for all of our services to make sure we have adequacy of network. So we're working on that now, and that will continue.

We also began a certification process for our day habilitation, which we haven't historically had. And that's sort of been going on in earnest since maybe the Fall. So, we'll be slowly flipping and getting all of our day habilitation providers prepared. We're working with our provider community, some of whom are here this morning, about preparing for this shift into fee-for-service, which has its own challenges in and of itself, and working with people on that.

Like I said earlier, we're going to be reassessing everyone in our system, according to the New Jersey Comprehensive Assessment Tool to make sure that we have everyone's needs, we know kind of where they are as we flip them into the system.

We submitted our Quality Plan for The Supports Program to the Centers for Medicare and Medicaid Services (CMS) maybe six to eight weeks ago or so, and we got some response. We're working back and

14

forth with them right now on finalizing our Quality Plan. And just a note on that: If you are aware or interested in this topic, DDD is really working on the Quality Plan that we had to submit to CMS for the purposes of The Supports Program. We're working on a much larger statewide Quality Plan for the entire system right now. So we've had a series of family, individual, and provider focus groups over the last couple months where you have a survey that will be out soon. We're working in conjunction with The Boggs Center, and some other partners. We do a lot of work around quality. So if that's something you're interested in, just keep watching our website and stay tuned for our updates. You'll see more about that soon.

So like I said, July 1st, we'll be enrolling individuals into The Supports Program. At that point in time, it will be any new presenters to our system enrolled, mostly that means people coming out of school and aging out of the Department of Children and Families (DCF) system, aging out of the Children's System of Care (CSOC) this year, will be able to go hopefully for the most part directly into The Supports Program right into services, which is great.

15

The last thing I just want to mention is we are working on some amendments with our partners at Medicaid. We've identified a series of amendments. Some of them are technical things, but things that we want to get in place if we can before we actually begin enrolling people in July that we're working with CMS on.

So we did a webinar back in December 2014 to present the amendments to stakeholders, so if you're interested in more information, that's archived on our website and you can certainly go on and look at that.

After the webinar, we gave an opportunity for stakeholder input. We got, a couple hundred e-mails in, input into some of the amendments, a lot of really helpful feedback, so that was great.

So we're submitting technical amendments that are really going to help in a lot of ways for some small gaps. So just give you an example, right now the terms and conditions of The Supports Program states that you cannot be enrolled in The Supports Program until you're both the age of 21 and you've completed your educational entitlement. That creates a strange gap because the DCF system really ends for people when they are age 21. So you could

have someone who turns 21 -- let's say they turn 21 in November -- they're still going to be in school until June. DCF services have to end and you've got those months that you need to fill in that gap. So without us making this adjustment, it would mean that we were going to step in and provide services to people during that period of time, it would have to be all State dollars, which doesn't seem to make a lot of sense. So we're working on getting that amendment. So, things like that that I think just made good common sense. And we're also working on a couple of substantive amendments. We're looking at creating two new eligibility categories which will help on the Medicaid side for some individuals who had some difficulties accessing Medicaid and thus getting into our system.

That's really all I had. I just wanted to give a quick update, but I'm happy to take questions if anyone has them.

DR. SPITALNIK: We'll turn to the members of MAAC.

Beverly.

MS. ROBERTS: You said two new eligibility categories. You knew I was going to ask a question.

MS. SHEA: You want to know what they

are?

MS. ROBERTS: Anything that you would like to share.

MS. SHEA: Sure. So let me take a quick step back, then, with that.

One of the other reforms that DDD has worked on over the last couple of years now is tying our program, in general, to the Medicaid system. So individuals now in order to maintain their DDD eligibility have to also be Medicaid eligible. In that process, we've identified a group of people who, because they fall in this strange carve-out situation where they started getting, inheriting maybe a family benefit -- typically it's a parent benefit that they start inheriting before they turn 18 because, let's say, a parent dies or something. So they're 16, their parent died, they started inheriting a parent benefit -- at that point in time when they then turn 18, they can't become what's called a Disabled Adult Child (DAC) to get into the Social Security system. It's a weird glitch in the regulatory structure. But because of that, we have this group of DAC people. It's a very small group we've identified at the Division across the entire State and across the system, and we've been really looking for them for two, three years now. So I

think it's a small population, but this identified group needs to figure out how to get into Medicaid. So that's one of the groups that we're adding to The Supports Program in order to help that group be able to get in. So they'll be able to access their Medicaid and be able to become a Supports Program participant and then also be in The Supports Program. So that's one eligibility group.

The other group is -- right now, our CCW has a higher income tied to it in terms of people's Medicaid eligibility because it's an institutional sort of income requirement. So what we're doing is raising the income requirement related to -- or attempting if we can -- raising the income requirement related to people on The Supports Program so we can equalize with the CCW so people will be able to get into either waiver at that institutional level.

DR. SPITALNIK: I had a question, Liz. There's been some concern for people who are in need of nursing services having to -- I may be portraying this incorrectly -- having to choose between either nursing services or the kinds of support services available in the CCW. How is that being addressed?

MS. SHEA: I appreciate that question. So that's our other major substantive amendment that

we're working on with The Supports Program. So we, again, historically have a group of people who, when they're under the age of 21, you can access private duty nursing through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) right in the Medicaid system. When they are 21, historically, it used to be that the way people could get private duty nursing through the State system was in our Community Resources for People with Disabilities waiver, which that waiver has now been folded into Managed Long term Services and Supports (MLTSS). So, the point is that we have this group of people that come out of school every year -- it's a very small number -- they come out of school and they require private duty nursing (PDN), but they also might have a developmental disability and could really benefit from employment and day supports that are offered by the Division and that people will be able to access from The Supports Program. The way the current system is set up is that you really you can't be on two different waivers, and our Supports Program terms and condition currently say that you can't access the Supports Program and be in MLTSS at the same time. So we're working on -- one of our main substantive amendments is exactly that, is to figure that out -- and there's a lot of technicalities about how to do it.

We've had a lot of discussions about how. But to figure out how to allow people to sort of straddle and walk that line and be able to access both The Supports Program services as well as the private duty nursing services is the discussion.

DR. SPITALNIK: Thank you.

Other questions from Members of the MAAC?

Dennis.

MR. LAFER: You spent a lot of time on the rate setting. I wonder if you can you talk a little bit about the results of the rate setting.

MS. SHEA: Sure. So we have a draft report that came out in July 2014. Again, there's a ton of information on our website depending on what kind of specific question someone might have about the rates or rate setting, the process. But we brought in a national rate setter. We worked with the Division of Mental Health and Addiction Services and have the same group doing the rate setting so we would have some consistency across that. And he put out the draft rates in July 2014. We had a couple of advisory stakeholder groups that we worked with. I'm trying to think of what the questions might be. Like I said, the draft rates are out.

MR. LAFER: Overall, have rates went up?

MS. SHEA: It depends on who you talk to. So DDD has long been a contract reimbursement system. We're all contract. We don't really have any -- little bits of fee-for-service, but most of our sister agencies have more of a half and half. We really have long been almost entirely contract reimbursement. So we have agencies that are under contract with the Division of Developmental Disabilities that got their contract in 1974, who haven't had much of an increase since then. And then we have others that came into contract with us in 2013 who have rates here. So the point is if the rates came in, some of the 2013 people might not be as happy, but the '79 people are going to be thrilled. It's really a balancing in order to get there. But the rates were set very specifically not with a "this is our overall budget, we have to divide up the money we have in mind." Philosophically, the way we went into the rate setting, we were very clear with our rate setter, "what is the cost to provide the service, what is the actual cost?" We looked at cost data, we look at what other states do. But what is the cost to provide the service. And if that means we can't fund them at a hundred

percent, then at least we know what the real cost is and let's set the rate there and then we can work from there.

So all that information is transparent. It's out there. The providers know exactly what the rates are and should be, according to our rate setter. I hope that's helpful.

DR. SPITALNIK: Any other questions from the MAAC?

I'll take one or two questions from the public or comments. And I'm reminding members of the public when you ask a question to give your name so we can record that in the minutes. Thank you.

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

You mentioned new eligibility categories for people who don't otherwise have Medicaid eligibility. There is a group of immigrants who when they're under 21 are not subject to the five-year bar, but when they reach 21 are. What consideration have you given to incorporating that group into the system?

MS. SHEA: Thank you for your question. When we changed our regulations to require Medicaid eligibility as a requirement, tying it to DDD services, one of the things we began immediately is what's called

our Medicaid eligibility project. So it's a staffed project where the entire goal is we've been collecting troubleshooting forms from all individuals across the system, anyone we identify who is having an issue with becoming Medicaid eligible. So since that time, I think it's over 9,000 people, a lot of people we've managed to actually get through the system. So that's the good news. We still do have, to your question, a small group of people. So one of them is this group of 125 or whatever it is non-DACs that we've identified that we're working through the project. On that particular question, from what I'm seen, the ones that have come through our Medicaid eligibility help desk, I only know of right now three individuals. And we've been so far holding services and they're almost at the five-year mark. So we don't have -- we haven't really yet to identify that as a big problem that we would want to put a new group in place for. But I think there's always opportunity for conversations around how to solve those gaps. I think it's an ongoing conversation, I'm sure.

DR. SPITALNIK: Thank you. Anything else?

Yes.

MS. PRATT: Nicole of Statewide Parent

and Advocacy Network (SPAN) there was an article that just came out over the weekend about certain adults already in the older DDD system moving over to the new system that are in particular programs and they fear that they would lose those programs. Is that going to be the case? Would they be able to stay in the programs that they currently have in the new Supports Program.

MS. SHEA: By and large, I'll say, especially with regard to The Supports Program, really in general in our system, The Supports Program, there are a couple of things that over the years DDD has provided. I'll give you an example. Cash, to give out. Those things can't be in a Medicaid-based environment -- they can't be. So there are a couple of little things. And largely, those changes and reforms have been made over the last couple of years anyway. So services that people are getting today in our system, by and large really shouldn't be shifting because of the stand up of The Supports Program. I mean, there are always things that -- so if we get a new court settlement, if Olmstead part 2 shows up, or the federal government says this is the way we now have to re-adjust things, things always can shift. But in general, I wouldn't be concerned at all. If someone's

getting something today, when they move into The Supports Program, by and large, they should be able to get that same thing.

Let me make one major caveat. The provider they're getting it from has to be ready, willing, and able to move into the new system. So we do have some providers who are saying, "I like having a contract where you pay me in advance for a level of service and I don't have to worry about vacancies and marketing and I don't want to do fee-for-service."

So, we can't force the providers to come along for the ride. So to the degree providers say, "I don't want to participate," then they might have to switch providers, but the service would still be available. They would just have to find a new provider, and we would help them to do that.

MS. PRATT: So it would behoove parents in their program that they're currently comfortable with their provider to really work with that provider to come onto the new system. I think that's where the anxiety is coming in at.

MS. SHEA: That's a great point, and I appreciate you saying that. And we've really been trying to stress that in our meetings and conversations with families, because we can say it too, and we do,

and we have a lot of dialog with our provider community back and forth. But I think it's a very different thing if they get a letter or call or whatever from the Division of Developmental Disabilities than if the mom that they see every day coming in and out of their door saying, "Are you involved in this new system? Have you looked at the rates? Are you going to go through the application? I went to a meeting. I heard this was happening." I think that's a great point.

MS. PRATT: It's the same question -- because I do a lot of the training for SPAN, and I do the transition training. So a lot of the parents ask me, well, I want to go to this program but I don't know if it will be paid for. So at least we have an answer to give them when we're doing this. Thank you.

DR. SPITALNIK: Thank you so much for that question.

MS. ROBERTS: I'm so pleased that you came today. Thank you. Do you think you might be able to come back the next meeting or two so we sort of see how things are progressing?

MS. SHEA: Absolutely.

DR. SPITALNIK: Thank you.

Our next items are presentations. And I thank our presenters for their patience over time.

We're going to have a presentation which is an overview of the Comprehensive Medicaid Waiver (CMW) evaluation Strategy. And I'm delighted to welcome Dr. Sujoy Chakravarty who is at the Rutgers for Center for State Health Policy. He's here with other colleagues: Joe Cantor and Christian Lloyd. And Dr. Chakravarty directing the evaluation of the comprehensive waiver. Thank you.

And as you mentioned earlier, these slides will be posted right after the meeting on the Medical Assistance Advisory Council site at: http://www.state.nj.us/humanservices/dmahs/boards/maac/.

DR. CHAKRAVARTY: Good morning. Thank you, Dr. Spitalnik for the introduction.

For the next 15 minutes or so, I'll try to take you through the salient points relating to the evaluation of the Medicaid Comprehensive Waiver.

(Presentation by Dr. Chakravarty.)

DR. SPITALNIK: Thank you so much.

I'll ask the members of the MAAC, if you will, if you might entertain some questions.

Wayne.

MR. VIVIAN: If the data proves disappointing, do we have to wait for 2017 before any changes are made? Or is that when the final

evaluations come out?
DR. CHAKRAVARTY: Well, the changes are made to what?
MS. VIVIAN: To, like, the whole waiver situation.
DR. CHAKRAVARTY: You mean the actual waiver?
MR. VIVIAN: Yes.
DR. CHAKRAVARTY: So we have the evaluation report which is due in 2017, so if you're saying there are some intermediate changes that are offering to the waiver, we do take that into account while conducting the evaluation process.
MR. VIVIAN: Right now there's no contingency plans? Like, if people are reporting that things maybe aren't working as well as they had hoped.
DR. SPITALNIK: I'd ask Director Harr to respond to that.
MS. HARR: So you can see when you heard Liz this morning that we're modifying things as we go along. And we've made technical corrections, we've changed course based on stakeholder feedback. And I think we'll continue to do that. And nothing should come as a big surprise, I think with any interim evaluation, so striking. We would know and we would be

changing course. We have to start thinking about the waiver renewal now. So I think that if we -- based on the stakeholder sessions that Rutgers has had and other forums, we could make and we have been making changes to the waiver programs.
MR. VIVIAN: Yes, that answers it.
MS. HARR: And I do expect we'll make changes when we look to renew the waiver.
MR. VIVIAN: Okay. Thank you.
DR. SPITALNIK: Thank you.
Other questions from the MAAC?
Beverly.
MS. ROBERTS: There are two very specific small beneficiary groups in MLTSS that I wanted to ask you about. The two beneficiary groups I wanted to ask about are those who previous were in the Traumatic Brain Injury (TBI) waiver and the CRPD waiver and are now MLTSS. The numbers are relatively small. Their needs are very unique and specific, and I'm wondering as you do the overall evaluation, will you be looking at those groups separately?
DR. CHAKRAVARTY: Yes. So there's a broad group and there are subgroups in between, and we will examine these subgroups too, to the extent that's allowed by data. Of course, when the sample sizes are

really small, sometimes there are statistical issues in terms of examining direct effects of policy on those groups. But to the extent possible, we will look into these specific categories.
MS. ROBERTS: I would appreciate that. Thank you.
DR. SPITALNIK: Sherl.
MS. BRAND: I was just wondering will the MAAC see the report? I don't know if we see a draft or only the final.
MS. HARR: So we haven't really discussed it. The draft, you said is due --
DR. CHAKRAVARTY: There's a midpoint draft, but the evaluation is due in fall.
MS. HARR: But the draft interim evaluation, the entire evaluation is July 2016?
DR. CHAKRAVARTY: Yes.
MS. HARR: We haven't discussed it, but I would think so.
MS. BRAND: I was just curious.
MS. HARR: The interim evaluation and then the final, certainly. But ongoing any interim reports, I think we would make available.
MS. BRAND: Would we be considered part of the stakeholder group?

MS. HARR: I think some of you already have been.
DR. CHAKRAVARTY: Yes, yes.
MS. BRAND: Thank you.
DR. SPITALNIK: Any other questions from the MAAC?
Dennis.
MR. LAFER: Under the MLTSS, mental health is included? Will you be looking at specifically the mental health piece under MLTSS?
DR. CHAKRAVARTY: Yes. We are looking at mental health hospitalization and behavioral health outcomes, yes.
DR. SPITALNIK: Thank you.
I'll entertain a few questions.
Yes.
MS. COLLINS: Maura Collinsgru from New Jersey Citizen Action.
You said the hospital survey is now available. Can you tell us where we could find that? And is that survey filled out by the hospital staff or by patients receiving the intervention?
DR. CHAKRAVARTY: It's by the hospital staff. So we receive it from the Department of Health (DOH) for every hospital, and we send it to them, so

it's for the hospital staff.
MS. COLLINSGRU: And that survey is available for viewing? Is that available to the public?
DR. CHAKRAVARTY: No, not yet.
MS. COLLINS: Okay.
DR. SPITALNIK: Thank you.
Ray.
MR. CASTRO: Ray Castro, New Jersey Policy Perspective.
What is the relationship between the evaluation and the State's establishing budget neutrality? And also, how does it fit into the State's decision on whether or not they are going extend the waiver or not? I'm just trying to figure out how this all this fits together.
MS. HARR: I would say I don't think there is a relationship between the evaluation and budget neutrality. The budget neutrality gets updated quarterly. So the evaluation is separate.
And I think similar to what I said before, that as we get the results, whether they're informal or interim, what Rutgers is doing, it will help, I think, to inform us on the waiver renewal. And at this point, I would expect that we would be looking

to renew the waiver because some of the initiatives have had a delayed start or we haven't launched some of the initiatives.
DR. SPITALNIK: Thank you.
Any other questions?
Hearing none, thank you so much for your presentation and to all of you for the work you do.
We'll now turn to another presentation, which is an overview of the External Quality Review Organizations (EQRO) Transportation Study. And I'm pleased to introduce Steven Tunney from the Office of Customer Serve of Division of Medical Assistance and Health Services.
MR. TUNNEY: Thank you, and good morning.
This was a report that we got from our EQRO the Island Perr Review Organization (IPRO), and I tried to take the data and present all the important and key components of our transportation brokerage contract.
(Presentation by Mr. Tunney.)
DR. SPITALNIK: Thank you so much for that excellent presentation.
Are there questions from the MAAC?
MS. BRAND: Yes.

Steve, thank you very much for the detailed overview.
With respect to the corrective actions, do you have a plan for a survey, another survey, just to see if there's been improvement with respect to the actions you've already started.
MR. TUNNEY: Yes. The IPRO who did this for us is going to repeat the survey. And part of what we are doing with our state monitoring unit -- I'll just expand on that a little bit -- we are going to mimic some of the things that they are measuring. We are also going to utilize some our MACC staff in the community to be at a facility when a client gets dropped off to see with our own eyes that they get the assistance, were they there on time, that sort of stuff. And we're also going to be doing a lot of the same kind of phone calls with the clients. So we'll be doing the follow-up within five days, give them a call: Were you satisfied? If you weren't, then we'll follow up with it from that end.
We're going to have the staff actually at the broker, but I'm going to utilize MAAC staff out in the community because that really seems to be really where the he-said/she-said stuff happens. So we're actually doing a "secret shopper" on the ride so that

the driver will not know that that is a Medicaid employee that will be on the vehicle, and then we can see if they're being rude driving, whatever is happening. And we're also going to make sure that they have -- we have a very inspection system for vehicles, and we want to make sure that the vehicle that is picking up that client is the vehicle that was approved to do the trip.
DR. SPITALNIK: And let me clarify, that's a different M-A-C-C, that's the Medical Assistant Customer Center (MACC).
MS. BRAND: The timing of the next survey? Six months from now?
MR. TUNNEY: I'm not a hundred percent sure. I think it's yearly.
MS. BRAND: It's really important, so...
MR. TUNNEY: Yes. Especially now with the increase in the Medicaid population. There's been a growth in some of the programs.
DR. SPITALNIK: Wayne.
MR. VIVIAN: First of all, I want to say that transportation consistently ranks at the highest unmet need for mental health consumers. They consistently talk about the lack of transportation is

one of their biggest challenges and biggest things that affects their lives in a negative way. I have a few questions.

First of all, regarding -- it might not be your issue, but it might be a Medicaid issue. When somebody chooses a bus pass or transportation, sometimes their condition deteriorates and it's difficult to transition from the bus pass then to the actual transportation. And sometimes you need that rapid turnaround, and it's really, really hard to transition from one to the other. Now, I don't know if that's a LogistiCare issue or if that's a Medicaid issue.

MS. HARR: I think it's our issue.

MR. TUNNEY: For the broker that we utilize, there is a process in place. So if you were to call and say that you had a medical condition now that warrants that you not use public transportation, we'll contact the physician to get the supporting documentation that we need. So there shouldn't be any kind of a lag in that.

MR. VIVIAN: We've had people in our program that have developed cancer and then they could no longer take the bus, they had to take transportation. And, you know, we couldn't get them to

their chemotherapy and all kinds of things. It was really difficult. We really had to jump through hoops to make those changes.

DR. SPITALNIK: Is it an informational issue that people don't know they can call the broker?

MR. VIVIAN: No. They know. We did it. As case managers, we did. We were involved in trying to get that done. And it really was difficult.

MS. HARR: What happened? Did the broker say, no, this client has a bus pass?

MR. VIVIAN: Yes.

MS. HARR: So maybe it's going back and re-educating the staff at LogistiCare about that process.

MR. VIVIAN: The other thing is that people with mental illness or any kind of cognitive disability, it's difficult for them to get Access Link -- and we always try to get people Access Link -- it's almost impossible. I've done presentations for Access Link. Anybody in mental health knows that for consumers of mental health services to get Access Link it s really, really difficult. And that's why it's really important. This is their only means of transporting, especially to medical appointments. I have to say that in our program, we do encourage

people, if it's possible, for them to take the bus because it fosters independence and those kinds of things. But there are people who absolutely cannot.

The other suggestion I have is maybe there just needs to be a little more flexibility in the program. Like, let's say somebody does need the bus or does accept the bus pass. If it's possible that maybe there are times when they just cannot take the bus, but if they could have maybe like where they're entitled to the bus pass for the month, but maybe they also could be entitled to, like, maybe three transports as well for those few times when they can't use the public transportation. Just that little bit of flexibility would make a big difference.

I think regarding, like, why some of the dissatisfaction, too, is sometimes the providers put pressure on the consumers and blame them for being late. And they say, well, what can I do if my transportation didn't get here? But, you know, sometimes the providers don't want to hear that. You're supposed to be here at 9 o'clock. So that may be one of the reasons why there's that dissatisfaction there.

But I have to say I am concerned. I don't know how realistic it is for some of these

providers to buy vans, insure them, all those kinds of things when you're going to reimburse them for the transportation. There are some programs I can name that do provide transportation, but oftentimes the driver's out sick and then they only have one driver and then the person misses their day program for a week because they don't the LogistiCare. So there really are a lot of complications. I know you have a really, really difficult job, but realize how important it is. I want to say how important it is what you're doing, because it really is. People with disability really rely on your services.

Overall, I think you do do a good job, from my experience. Just these few things. Maybe a little more flexibility, some things like that.

DR. SPITALNIK: Thank you so much. Theresa.

MS. EDELSTEIN: Just a quick question. Some time ago a draft Request for Proposal (RFP) was issued. Can you comment at all on what the timing might be for the final RFP?

MR. TUNNEY: I asked right before I came here this morning, and I was told if all goes well right now the Comptroller's Office should release it within 30 days.

MS. EDELSTEIN: Thank you.
DR. SPITALNIK: Any other questions?
Any questions from the public?
MS. MCDONALD: Hi, I'm Crystal McDonald from Faith in New Jersey. So I'm really excited to see you guys did an independent study on LogistiCare. Is it going to be available online, the full report?
MS. HARR: The slides will be. We'll definitely consider it. It's a pretty lengthy report.
MS. MCDONALD: I like reading.
MS. HARR: I've shared it with a few of your colleagues.
MS. MCDONALD: Did studiers have any questions about the data quality from LogistiCare? Were there any questions about the data quality?
MR. TUNNEY: IPRO made a couple suggestions to the broker related to some of the data was collected that they submitted a report to us to clean things up on their end. One of them was the 20-something percent that didn't have a reason listed for why a trip was canceled, things along those lines; there were trip reports where times weren't filled out correctly or it didn't make sense. You can't have three trips in a row that were all picked up at the same exact time.

So that information was shared with them, and they are working on corrective actions on their side. And we definitely cleaned up some of the data -- this is the actually the second IPRO report that we received. The initial one, it was a couple more issues. So they've cleaned up the data.
MS. MCDONALD: Okay. Great.
And then one final question was just around the collection of patient feedback. Are you guys thinking of having IPRO do anything besides making phone calls to the households? It didn't seem super successful. And in our experience, problems with cell phone minutes and changing of phone numbers makes it difficult for that to be the primary way to reach out.
MR. TUNNEY: Like I said, I don't know that we're going to change the way IPRO does it, but with my staff, we are going to, first of all, do repeated phone calls. So if we don't get ahold of the person the first time, we'll try to get back to them. And the other one is we have talked about doing it in, like, a written survey. But the results from the written surveys tend to be a little lower coming back. And we have some issues with address changes, and things like that.
MS. MCDONALD: One thing that we're looking at is actually having the surveys done in the provider office so that the patient can give feedback there and it's an easier way to collect it and cheaper than mailing it out. Just a thought.

DR. SPITALNIK: Thank you so much.
Any other comments from the public?
Yes, Joe.
MR. MANGER: Joe Manger from Horizon Blue Cross Blue Shield of New Jersey.
I want to thank you for recognizing some of the issues that exist that I can personally attest to. A lot of these corrective action plans are already paying off. As folks probably know, majority of the individuals are in managed care so the link between vendors, i.e., those arranging for the transport for the medical appointments that I'm covering is really key. And Steve and in particular Maribeth had really stepped up an active oversight role of LogistiCare. They were in to do an in-service to Horizon staff, which we found infinitely helpful. So I just wanted to comment that. I know statistics will be coming and we'll be studying other stuff, but as it related to the immediate corrective actions, we've seen immediate resolution to some of the most prominent questions about no-shows, not scheduling enough time.

We have an escalation, so I can't comment -- I don't have the experience that Wayne has with that benefit because it's not something that we encompass all the time, but the routine transport seems to be going much better.
MR. TUNNEY: After we met with you, we opened it up now to the other health organizations. It did go well, and there is definitely a benefit of working with you guys to coordinate the information and find specialists that are closer or if we can get a service in the home where it's difficult to get people out, down steps. It's unfortunate the number of people that are in housing situations that just make transportation very, very difficult, like narrow steps. But that was a good thing to work out. LogistiCare is more than willing to talk to any provider and work with them if they have specific issues.
They just hired a new transportation manager for facilities. So as soon as they get their feet a little bit wet, then we'll get them back out and they should be traveling to any providers where we have consistent issues. I use them a lot when I get calls into my office, and they're very responsive.
MR. MANGER: Steve, could I just add, this was really key to our clinical staff. They do

have a medical director. I didn't know that. But there is a medical director at LogistiCare that our medical director can coordinate with, which is really critical, because I know that was some of the issues we talked about, dialysis, some of the other issues. But just that addition, I think that did a lot to reduce stuff a little bit because there was a tendency to think, oh, it's just arranging trips. But that was a tremendous improvement to the process. So I just wanted to call that out.

MR. TUNNEY: Thank you.

DR. SPITALNIK: Thank you so much.

The rest of our agenda is a series of informational updates. Director Valerie Harr is scheduled to do the first two and then the seventh, so I'm going to ask her to cluster all of her updates. Thank you.

MS. HARR: I'm just going to provide an update to the enrollment statistics focussing on the expansion population. I've been providing this type of update probably since 2014.

(Presentation by Ms. Harr.)

DR. SPITALNIK: Thank you.

Yes, Mary.

MS. COOGAN: I know the past months

have not been easy, so I think this is really wonderful, the automation. One question to clarify about NJ FamilyCare where you're saying people can set-up accounts now, that's for new applications. What if you're already in the NJ FamilyCare system? Should people be going online to create some type of account?

MS. HARR: No. We haven't launched that yet. It should be soon. It would be for someone creating a new application.

MS. COOGAN: So at some point, existing applicants will be told to create one?

MS. HARR: Yes, I think at some point -- and if you're doing a re-determination, so you can be an existing applicant and I think Xerox is requesting renewals to also be done through njfamilycare.org, and they can create an account then.

I mean, ideally, we want everybody to have one -- ultimately, we want to be able to communicate electronically, via e-mail, and so forth. So this is just, I think, the first step.

MS. COOGAN: So no one should proactively --

MS. HARR: No. This is really part of the process of submitting an application for NJ Family Care. It's not just creating an e-mail account for us

to communicate with. We're not there yet.

MS. COOGAN: Okay. Thanks.

DR. SPITALNIK: Beverly.

MS. ROBERTS: I have a question about re-determinations for the small group of people that I deal with a lot, the DACs, the people who are considered Disabled Adult Children, so they did have SSI and Medicaid. Then mom or dad retired or one became disabled or passed away, and then they got SSD on that parent's work history. Let's just say it's $1,300 a month. So they would be considered not eligible in general for Medicaid, but they can get it because they previously had SSI. There's this regulation that allows it under the Social Security regs.

MS. HARR: Okay.

MS. ROBERTS: Are those people supposed to do a re-determination every year?

In the past, I don't think this was happening, but this is question that has arisen. Do they have to essentially apply for Medicaid again every year?

MS. HARR: It should be, I think. I don't have an eligibility person with me, but before they should receive notice, I would assume they would

receive notice that they would be losing the benefit, but then the county welfare agencies should be screening the individual for any other Medicaid program information.

MS. ROBERTS: It's not so much that they're getting it initially. That was a problem before. I think that's by and large that has been fixed. I'm just saying annually every year after that, after that has occurred.

MS. HARR: I would say yes, but I should check. If you could send me the question in writing and we can get back to you.

MS. ROBERTS: Okay. Great. Because it could be very burdensome to have to go through full application every year.

MS. HARR: Could you e-mail me with the question and we'll ask an eligibility person.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Josh.

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

First of all, I think the number of new people who have been approved in this short period of time, 420,000, is great. It's a remarkable success. And these are people who didn't have coverage

previously, so I want to thank you and the Division for your efforts in doing that.

I have a question about denials and also appeals of denials. Do you keep track? Do you have that information? I think you mentioned in one of the other meetings about the volumes of the denials each month and then appeals from those denials.

MS. HARR: We have denial information from the Health Benefits Coordinator (HBC), and we have denial information of the county welfare agency (CWA) is using the administrative tool that we've established. There's a drop-down menu for them to say, was what application approved, is it pending, was it denied. So it wouldn't be complete, but we do have -- and if the slide isn't here, I do have a slide on the denial information.

And then what was the second part of your question?

MR. SPIELBERG: And when I say denials, I also mean terminations. Do you have data on how many people appealed those ineligibility determinations?

MS. HARR: Again, it would be the health benefits coordinator or we would have the fair hearing information. So, again, if you want to follow-up with me and I'll see what we have.

DR. SPITALNIK: Joe.

MR. MANGER: Joe Manger, Horizon Blue Cross Blue Shield.

Just a quick question. I want to make sure I heard it right. Great job on the backlog. Obviously, that's huge.

You mentioned 9,000 to 12,000 backlog. Is that per county except for those three?

MS. HARR: We ask all 21 welfare agents to report. Now the majority of the counties are reporting. So it's statewide. So 9,000 to 12,000 are reporting weekly of cases that are over 45 days.

MR. MANGER: Statewide?

MS. HARR: Statewide, yes.

MR. MANGER: Thank you. That's helpful.

DR. SPITALNIK: Kathy.

MS. O'BRIEN: Kathy O'Brien, Star Ledger.

What's the financial underpinnings of, I assume, Xerox's getting paid more to do more work?

MS. HARR: There was a contract extension and so the reimbursement to Xerox to do the additional work is part of the extension of the Xerox contract.

MS. O'BRIEN: And how much is it?

MS. HARR: I don't know off the top of my head. I don't have the amount.

DR. SPITALNIK: Maura.

MS. COLLINSGRU: Maura Collinsgru, Citizens Action and NJ for Health Care. Thank you for the comprehensive update in what has been a very challenging situation everywhere.

What we did receive those numbers of the backlog through an OPRA request, as you know. And it was at the end of February, 9800, with three counties, Essex, Passaic, and Middlesex, not reporting. Are those counties now reporting? And are you including them in that 9,000? Or are they still unknown in those three counties what the backlog is?

MS. HARR: Well, the counties that report vary each week, so some weeks just the county forgets, doesn't report. When I say the 9,000 to 12,000 for that last week, I don't have the list of counties in front of me.

MS. COLLINSGRU: Okay. But at some point you are getting reports from all of the counties?

MS. HARR: Yes.

MS. COLLINSGRU: Just maybe not every week?

MS. HARR: Yes.

MS. COLLINSGRU: Okay. CMS was reporting that the expectation was New Jersey backlog would be cleared by May 1st. Is that, in fact, a realistic projection?

MS. HARR: It's close, because this week -- I said we're moving the remaining 9,000 to 12,000 backlog to the HBC. I think May 1st is aggressive, but I would hope by May through May, yes, we should have the backlog cleared.

MS. COLLINSGRU: And one final question. You said Xerox will process all the re-determinations for those who applied at healthcare.gov?

MS. HARR: Yes.

MS. COLLINSGRU: So that question is 450-some thousand?

MS. HARR: No. The re-determinations that the county welfare agencies are responsible for is 450,000. I think the re-determinations for the Marketplace is closer to, I'd say, between 150,000 and 200,000.

MS. COLLINSGRU: And they'll be contacted via mail? Or will it be through e-mail?

MS. HARR: It will not be through

e-mail. It will be through either mail or telephone.
MS. COLLINSGRU: Okay. Thank you.
DR. SPITALNIK: Thank you.
MR. CASTRO: Ray Castro, New Jersey Policy Perspective.
In terms of the best of the Consolidated Assistance Support System (CASS), it sounds like you developed a lot of work around strategies. And so is this in lieu of CASS, or is this going to be developed at some point? I'm just wondering how this fits together.
MS. HARR: We did develop a lot of these strategies. So the Modified Adjusted Gross Income (MAGI) in a cloud and streamlined application at njfamilycare.org were put in place even prior to January 2014. Now we've continued to enhance it, because we know that the contingency had to be expended because the CASS project was terminated. The CASS project is over. We are in the process of conducting -- we have a vendor doing a gap analysis to determine functional and business assessment of what could be reused from the work from CASS and strategies for all of the Medicaid and social programs going forward. So that is in process.
In the meantime, we will continue to

build and enhance our technology and utilize the HBC as much as we can.
DR. SPITALNIK: Thank you.
And the other two updates.
MS. HARR: Yes.
DR. SPITALNIK: Thank you so much.
MS. HARR: I'm not sure if it was Sherl or someone had asked for an update on the home health care regulations.
The rule expires in 2020, but we are making amendments. I have not seen the amendments yet. They have been worked on with staff and are going through circulation internally for final review. And my team tells me that we're anticipating they will be sent Commissioner's Office and the Office of Administrative Law in the spring.
DR. SPITALNIK: Thank you for that.
And an update on Accountable Care Organizations.
MS. HARR: We're so close with the Accountable Care Organizations (ACOs), very, very close. We sent a list of questions and outstanding information to the applicants in December 2014. We gave the applicants 60 days to respond. They all did in February. One of the outstanding items was how to

determine and what the physician participation number should be for those geographic areas that each applicant had identified. And we have used our encounter and claims data to be able to identify the number of participating primary care providers in each of the ACO geographic areas so that we can now work with the health care quality institute that represents each of the ACO applicants. We hope to finalize and firm that count, that physician versus patient count, lock that down hopefully this week. And we still are reviewing the rest of the materials, not just that piece that was outstanding, and hope to get back to the applicant and certify the ACO eligible applicants within the next few weeks with, hopefully, a target launch date of the ACO demonstration in the summer.
DR. SPITALNIK: Thank you.
I'm going to go out of order on the agenda and ask Roxanne to give us the Behavioral Health Home State Plan Amendment next. Thank you.
MS. KENNEDY: Good morning. I'm going to talk briefly about our Behavioral Health Plan and give you an update of where we are Behavioral Health Home (BHH), as well as our Interim Managing Entity (IME) that we're working with in State.
(Presentation by Ms. Kennedy.)

DR. SPITALNIK: Thank you.
Questions from the MAAC.
Dennis.
MR. LAFER: Are there still active plans to publish an Administrative Services Organization (ASO).
MS. KENNEDY: The RFP is still in the procurement process for the ASO.
MR. LAFER: So there are still plans to send it out?
MS. KENNEDY: That's the plan today.
DR. SPITALNIK: Beverly.
MS. ROBERTS: Do you anticipate that is starting now with the IME will be expanded to cover people with behavioral health needs?
MS. KENNEDY: When you say behavioral mental health --
MS. ROBERTS: This is non-addiction.
MS. KENNEDY: This is Phase 1. Maybe Lynn Kovich could provide more detail. I don't know that we know what Phase 2 is. The Community Support Service, I think the intention is to have Universeity Behavioral Health Care (UBHC) manage that service, which is a mental health service. I think that was always the intent to have that service managed by an

entity. So that will be the first entry into having mental health managed in our system, and that should happen sometime early in 2016.

DR. SPITALNIK: Any other questions from the MAAC?

Phil and then Maura.

MR. LUBITZ: Phil Lubitz, National Allinance on Mental Illness of New Jersey (NAMI NJ). So there is an advisory group of substance abuse providers working with the IME but they're going to be moving Community Support Services into the IME, so is there going to be a way that mental health providers could provide input to the IME?

My suggestion would be, since we now have a Behavorial Health Planning Council that is represented by both substance abuse and mental health that we consider using that as a vehicle for input into the IME.

MS. KOVICH: There is one distinction with our Community Support Services (CSS) and UBHC managing them. They will actually only be authorizing the services in six-month increments because of the type of service that it is. So they will not be referring to different agencies. They'll really only be approving the plans of care that are developed for

folks. But nonetheless, that is a good suggestion to use the Behavioral Health Council.

We've not started the CSS piece -- well, informally we have. But as you imagine, most of the work has been around addiction since that's going to launch July 1, 2015 and CSS won't launch until January 1, 2016. But that's a good suggestion.

DR. SPITALNIK: Thank you.

Maura.

MS. COLLINSGRU: Maura Collinsgru, Citizen Action.

Has there been any plans put in place for the rate increases that have been being studied and discussed? Because I know there's been a lot of concern in both of substance use disorder and mental health field that one of the huge problems is lack of participating providers and lack of access to enough treatment providers. So there's some concern that just a gatekeeper to shuffle too few services is not really going to help. But is there anything coming online that's going to help increase access to actual treatment?

MS. KENNEDY: I'll let Lynn Kovich answer that.

MS. KOVICH: So part of the reason

we're doing this interim step with UBHC to a raise some of the addiction rates. Our addiction providers are already in a fee-for-service business. But most of the new expansion benefit is for people who have addictions. So we know our addiction providers are struggling, as the Division has been requiring them to become a Medicaid provider and if it's Medicaid-eligible service and a Medicaid-eligible person to bill Medicaid, knowing that the rate study is not complete. So as an interim step, we're going to raise some of the rates to the State fee-for-service rate that the Division is paying for people who historically have mostly not been Medicaid eligible. And the State plan now, as I said, is very heavy for folks with addiction. The current state plan is not. So that is an interim step.

Our mental health providers, although also are very anxious to get the rates, they are still in a contract deficit funded model. So we will not make the switch to fee-for-service under this true new market rate until we get to the second step of the reform, which is really then at that time the full system implementation of a fully managed system of care. So that's why some of the steps -- we're going in steps. We're still actually digging down the rate

study. Liz spoke about the DD rates being already released, and now, I guess, a more refined version of those being released to our DD providers. Mental Health and Addictions have not released any rates to our providers. And we probably won't do that until the beginning of this summer, the beginning of next fiscal year. And that's really just because we've been doing -- we have a very pretty complicated service system and each service has its own rate. So it's been a pretty tedious process to review the work that the rate-setter did.

MS. COLLINSGRU: Just one follow-up. Will a provider or nurses or -- I think it's Rutgers social work doing this?

MS. KENNEDY: It's University Behavioral Health Care, which is now a part of Rutgers. They're a behavior health provider.

MS. COLLINSGRU: Will they be able to override a provider recommendation?

MS. KOVICH: Some of the stuff that Roxanne talked about will be actually implemented in phases with the launch on July 1, 2014. But really how the system will work is they'll get an approval to do the assessment. Just like any managed care setting, they'll do an assessment. Based on the assessment, the

provider will recommend a level of care. We'll go back to UBHC to get approval to provide that level of care. And if the clinical documentation isn't such that that the level of care is deemed necessary, then the care would be denied and then the appeal process would be put into place. But that's exactly what the managed care system will look like when we get to the full implementation.

DR. SPITALNIK: Thank you.

Anything else?

Roxanne, thank you very much.

Deputy Commissioner Lowell Arye to talk Managed Long Term Services and Supports.

MR. ARYE: Good afternoon. I'm going to talk about three things, two of which are really more MLTSS and one which isn't, but I've had oversight over it as well. So we'll talk about the MLTSS update, including dashboards. Also an update on the Balancing Incentive Payment Program (BIP) will be shared as well as the Home and Community-Based Services (HCBS) Settings Rule.

(Presentation by Mr. Arye.)

DR. SPITALNIK: Do you want to MLTSS questions first?

MR. AYRE: I can do that.

DR. SPITALNIK: Let's do that.

Dennis.

MR. LAFER: Report of denials and appeals?

MR. AYRE: We don't yet have that. We literally just got that about a month ago, I think, because they didn't have to report for a certain number of days past the quarter, so we're just getting that. We have seen and we've actually asked people to do more appeals specifically if they're concerned. I think that there have been some more appeals. We're talking with the Community Health Law Project at a conference that they just had. The attorneys have seen some more appeals, but I think we're also seeing a lot more continuity of care too.

MR. LAFER: When will we see a report on this?

MR. AYRE: I think we'll see it probably in the next quarter.

DR. SPITALNIK: Theresa.

MS. EDELSTEIN: Thanks for this. Just a clarifying question. On the slide that says nursing facility population decreased by over 1500 since June 2014, is that the nursing facility population paid for by Medicaid, or is that the number of people who left

the nursing home?

MR. AYRE: No, that is definitely Medicaid patient days. So those are the numbers of people and patient days that Medicaid reimburses.

MS. EDELSTEIN: So it's possible that some of the nursing home residents might have gone out to the hospital and came back under Medicare, Medicare benefits, are, in fact, still in the nursing home, they're just not being paid for by Medicaid at that point in time?

MR. AYRE: That's possible, but also, as you know, we've seen a significant downward trend in number of patient days across for the last several years, so that's what we're seeing. And, yes, the 1500 may be a smidgen of all those kind of data points not matching correctly, but we're seeing absolutely a very significant change in nursing home patients.

MS. EDELSTEIN: Okay. Thanks.

DR. SPITALNIK: Other questions from the public?

Yes?

MR. WESSEL: Ken Wessel from the Home Care Council of New Jersey.

You obviously know these figures a lot better than I do so you can help me understand the data

going forward. The decrease in nursing home population doesn't seem to have a commensurate increase in home and community base services. If you could explain that to me. I'd like to know what's happening to those folks.

MR. AYRE: Actually, I think it does.

MR. WESSEL: If you look at the first line graph.

MR. AYRE: So as you can see, if you look at the blue line there is an increase in the numbers. It's not fully commensurate.

MR. WESSEL: Well, the blue line goes down, like 2,000; and the tan line only goes up a few hundred.

MR. AYRE: A couple hundred. That's true. And I can't give you an exact explanation for that.

MR. WESSEL: I think conceptually we'd like to understand.

MR. ARYE: Well, it's not just the numbers. Some of these individuals may be receiving State Plan Services and may not necessarily be -- medical day care, for example, and some other State plan service. Personal Care Assistance (PCA) is a State plan service, it is not a HCBS or MLTSS service.

So there can easily be another reason for that.
DR. SPITALNIK: Any other questions?
Let's go on to the BIP.
(Presentation by Mr. Ayre.)
DR. SPITALNIK: Comments?
Thank you so much.
Our next update is On Personal Care Assistance Tool, Carol Grant, the Chief of the Office of Managed Care, and Maribeth Robenolt, MLTSS Quality Monitoring.
MS. GRANT: Actually, it's very good that Maribeth is up here with me. She's going to come after me. I'm going to give you just a brief update of where we are with the PCA tool. The Managed care Organization (MCO) staff trainings on the new PCA tool which are conducted by the State were held in October 2014, with over 300 individuals participating. In January 2015, the new PCA Assessment tool went into effect for all PCA assessments. No other tool will be used to do those assessments after January 1, and they will be used for the initial or the six-month re-assessment and for changes in condition.
We extended an e-mail address for the PCA Assessment Tool that was maintained during the roll-out as a resource for MCO staff to ask questions

and receive clarification from the State related to the new tool. There were really very few questions raised because we really have tried to put a lot of our efforts into the training and a great deal of detail about how to handle the Tool.
We did indicate that we were going to be doing a webinar on the assessment tool. It is under development and will be posted to the Division's website. The webinar will review the purpose of the PCA Assessment Tool, provide screen shots of the Tool, along with a general instruction about how each section should be completed. Once the webinar is posted to the site -- a link will be sent to the MAAC at least for a heads-up so they get it first. And then it will be made available on the web. And that's kind of where we are now.
One of the reasons why we have not done a wide-spread distribution of the Tool is one of the problems we had last time there were multiple tools available. Nobody knew which was the real Tool. So we're managing the release of the Tool.
DR. SPITALNIK: Thank you. Any questions for Carol?
Yes?
MS. SALOMON: I just wanted to clarify.

Someone who is already receiving PCA services, they're supposed to re-assess every six months?
MS. GRANT: In general, yes.
MS. SALOMON: Okay. Because we've had some issue where someone was reduced PCA last year. The assessment was done in July-August 2014. We have appeals pending and they are at hearing levels, and they're probably due for re-assessments.
MS. GRANT: They probably are.
MS. SALOMON: Except that they're not always being done until maybe we get in front of a judge and they order that it be done.
MS. GRANT: That's true. I think that's a decision you have to make. The appeal will be based on the tool that was used. The re-assessment will be done using the new Tool. So I think you have to think through how you want to handle that.
DR. SPITALNIK: Your name, please?
MS. SALOMON: I'm Kimberly Salomon with the Community Health Law Project.
DR. SPITALNIK: Thank you.
Maribeth is up next to talk about the National Core Initiatives.
MS. ROBENOLT: Good afternoon. I'll try to be brief. I just want to provide a quick

background about the National Core Indicators for the Aging and Disabilities Initiative (NCI-AD).
(Presentation by Ms. Robenolt.)
DR. SPITALNIK: Questions? Comments?
Thank you.
And last, but certainly not least, Dr. Lind to talk about Provider Credentialing.
DR. LIND: Good afternoon. I wanted to provide an update of the activities of the Credentialing Task Force. I need to provide a little bit of background. Our Credentialing Task Force was comprised of representatives of all of our MCOs, the Department of Banking and Insurance, the Medicaid Fraud Division, and representatives of the provider community. We came up with a recommendation; that being, in order to achieve the five goals of optimizing member access to providers, improving provider satisfaction, eliminating redundancy, reducing unnecessary administrative burden, and achieving overall cost savings. The New Jersey Medicaid Credentialing Task Force recommends centralizing the collection of provider data, the performance of primary source verification, and the synchronization and coordination of the credentialing and re-credentialing process through the use of a third party vendor,

pertaining specifically to medical, dental and behavioral health providers.

That recommendation was returned in October, and we are currently in the process of internally reviewing the most efficient, cost-effective, and enacting the most smooth transition to the new process as possible, and the State is internally reviewing that currently. That's where we are.

DR. SPITALNIK: Thank you.

Any questions or comments?

Yes?

ATTENDEE: Medical Society of New Jersey. So is this the first time you'll be using a third-party provider to assist with credentialing?

DR. LIND: Correct. It's the first time that we're going to uniformly use it between the plans and fee-for-service.

Any other questions? Okay. Thank you.

DR. SPITALNIK: Thank you very much.

At this point, as we move very close to adjournment, our next meeting is Monday, June 15th, at the same location. I usually ask for agenda items that came up from our conversation. The one I had was a report on the appeals through MLTSS.

There was some question about the eligibility categories about the draft report from the waiver. But that item, the timing, I don't think that meshes with the June meeting.

Are there other items from the MAAC?

MS. ROBERTS: An update on The Supports Program. An additional update maybe on credentialing.

DR. SPITALNIK: Okay. Anything else from the MAAC?

MS. EDELSTEIN: RFP for the transportation broker, we may want to hear some more on that.

DR. SPITALNIK: Broker transportation.

And I would think we'd also want to have an update on the ASO and the ACOs.

Anything else?

Do I have a motion to adjourn?

MS. ROBERTS: Motion to a adjourn.

DR. SPITALNIK: Roberts.

Second?

MS. LIBMAN: Second.

DR. SPITALNIK: All in favor?

Thank you all very much for both your attendance and your endurance, and we look to seeing you in June.

(Meeting concluded at 1:09 p.m.)

Post-meeting addition: Listen to the Division of Medical Assistance and Health Services' PCA Tool Webinar at: Https://meetings.webex.com/collabs/url/QJLPSusAsok__haBwiR33qTNA_JjZKnbVqM7bbJl7fy00000.

C E R T I F I C A T E

I, Lisa C. Bradley, a Certified Court Reporter and Notary Public of the State of New Jersey, do hereby certify that the foregoing is a true and accurate transcript of the summary of the proceeding as taken stenographically by and before me at the time, place and on the date hereinbefore set forth, to the best of my ability.

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LISA C. BRADLEY, CCR

CCR NO. 30XI00228700