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, 2017
10:12 A.M.

FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Wayne Vivian
Sidney Whitman, DDS

Members Excused:
Sherl Brand
Mary Coogan
Dorothea Libman

Members Unexcused:
None.

State Representative
Meghan Davey, 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:

Mark Walther	AbbVie
Cheryl Reid	Aetna Better Health New Jersey
Cathy Chin	Alman Group, LLC
Alison Dorsey	Amerigroup
Brian Atkisson	Association of New Jersey Chiropractors
Matthew Minella	Association of New Jersey Chiropractors
Jennifer Black	Beacon Health Options
Kitty Lathrop	Burlington County Board of Social Services
Hilary Pearsall	Camden Coalition of Healthcare Providers
Colleen Woods	CMH Consulting Group, LLC
Cheryl Golden	Cumberland County Board of Social Services
August Pozgay	Disability Rights of New Jersey
Lauren Agoratus	Family Voices NJ
Tom Dorner	Health Care Association of NJ
Chrissy Buteas	Home Care and Hospice Association of NJ
Heather Watson	Horizon NJ Health
Carol Katz	Katz Government Affairs
Josh Spielberg	Legal Services of NJ
Alexis Arquello	Liberty Dental Plan
Chris Walley	LIFE St. Francis/PACE
Leuranda Koleci	Medical Transportation Association of NJ
Cynthia Spadola	Mental Health Association of New Jersey
Amanda Shiber	Medical Society of New Jersey
Amanda Cortez	Medical Transportation Association of New Jersey
Leuranda Kolci	Medical Transportation Association of New Jersey
Phillip Lubitz	National Alliance on Mental Illness NJ
Ksenia Lebedeva	NJ Association of Mental Health and Addiction Agencies
Lorraine Scheibner	Monmouth County Board of Social Services
Kevin Casey	NJ Council for Developmental Disabilities
Paul Blaustein	NJ Council for Developmental Disabilities
Dennie Todd	NJ Council for Developmental Disabilities
Grace Egan	NJ Foundation for Aging

ATTENDEES:

Melissa Chelker	NJ Foundation for Aging
Crystal McDonald	NJ Health Care Quality Institute
Kim Higgs	NJ Psychiatric Rehabilitation Association
James McCracken	Office of the Ombudsman for the Institutionalized Elderly
David Drescher	Office of Legislative Services
Robin Ford	Office of Legislative Services
Karen Shablin	Optum, Inc.
V. Plaza	Otsuka Pharmaceutical
Samuel Weinstein	Princeton Public Affairs Group
Mary Kay Roberts	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Ron Poppel	Sunovian
Tony Severoni	Sunovion
Julie Caliwan	The Innovation Collaborative
Kim Todd	The Innovation Collaborative
Zinke McGeady	Values Into Action NJ
Deborah brown	WellCare
Nancy Tham	WellCare
Roxanne Kennedy	NJ Department of Human Services
Laura Otterbourg	NJ Division of Aging Services
Freida Phillips	NJ Division of FamilyDevelopment
Marie Snyder	NJ Division of FamilyDevelopment
Don Catinello	NJ Medicaid Fraud Division
Linda Edwards	NJ Division of Medical Assistance and Health Services
Carol Grant	NJ Division of Medical Assistance and Health Services
Dr. Thomas Lind	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services
Matthew Shaw	NJ Division of Medical Assistance and Health Services
Maribeth Robenolt	NJ Division of Medical Assistance and Health Services
Heidi Smith	NJ Division of Medical Assistance and Health Services
Dr. Bonnie Stanley	NJ Division of Medical Assistance and Health Services
Joseph Vetrano	NJ Division of Medical Assistance and Health Services

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, the Chair of the MAAC, and it's my pleasure to welcome you to the April 13 meeting.

I want to let you know that pursuant to New Jersey's Open Public Meetings Act, adequate notice of the scheduled quarterly meetings for calendar 2017 of the Medical Assistance Advisory Council (MAAC) was issued by the Department of Human Services and was posted and transmitted in compliance with that regulation.

I also need to let you know on behalf of our facility host, the State Police, that in the unlikely case, upon hearing the fire alarm or evacuation announcement, please follow the directions of the staff; or absent that, quickly leave the building via the nearest exit, go to Lamppost No. 9 in the large parking lot. Once there, attendance will be taken, then wait in your designated area for instructions from emergency response personnel.

What I will do is review the agenda and the ground rules. We'll start with introductions, approval of the minutes. We have a presentation from Dr. Stanley and then we have a series of informational updates.

Our practice is the members of the MAAC will

introduce themselves. We will ask the members of the public to introduce themselves. That's only an introduction and an affiliation, not a time for a statement.

We have very much appreciated that we have been able to, despite the size of our group for which we're gratified by with so many people in attendance, we have been able to have dialog but with the following ground rules: That the members of the MAAC either ask questions or make comments. We will then turn to the members of the public. We will ask you to keep your comments or questions brief. And we have never had to, and hope never have to, resort to an isolated period of comments at the beginning or end of the meeting. It has clearly enriched our dialog and really supported the purpose of the MAAC to advise the Division of Medical Assistance and Health Services (DMAHS) and also to serve as a forum for stakeholder input.

So with that, let me ask my colleagues to introduce themselves.

I'm going to ask when you introduce yourselves to project your voice, and when you make comments or questions to stand and introduce yourself by name.

(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Thank you so much. Thank you, everyone. And welcome, everyone. As always, we appreciate your presence and interest.

Our next agenda item is the approval of the minutes, and we have two sets of minutes to look at. I'll start with the most recent, the January 23, 2017, minutes, do I have any comments or corrections or a motion to approve?

MS. ROBERTS: Do we have enough people here.

DR. SPITALNIK: Yes, we do. Thank you for that. Yes, we do have a quorum to be able to approve.

DR. WHITMAN: I make a motion to approve.

DR. SPITALNIK: Whitman motioned.

MS. ROBERTS: Second.

DR. SPITALNIK: Robert second.

All in favor?

Any abstentions.

We've approved the January 23rd minutes.

I'll now go to the October 19, 2016, minutes. Do I have any comments or corrections?

Hearing none, do I have a motion.

MS. EDELSTEIN: Motion to approve.

DR. SPITALNIK: Edelstein motioned.

MS. ROBERTS: Second.

DR. SPITALNIK: Second, Roberts.

All those in favor?

The minutes are approved.

And as always, thank you, Lisa Bradley, for these.

Our first item of business is a presentation on NJ FamilyCare Dental Services. And it is my pleasure to introduce Dr. Bonnie Stanley. Dr. Stanley is the Dental Director for the Division of Medical Assistance and Health Services.

Welcome, Dr. Stanley.

DR. STANLEY: Good morning. Well, I have to say I am delighted to be here to give the information about our dental program. So as you were just told, I am Dr. Bonnie Stanley. I'm the Dental Director for the NJ FamilyCare program. This morning I'm going to be giving you an overview of our program. And the topics that I will be covering are, the dental program's history from Medicaid to NJ FamilyCare, dental benefits and the costs, program policies and regulations, understanding dental activities of the managed care organizations (MCOs), partnering with the dental community, and the efforts that we have in supporting oral health in New Jersey.

(Presentation by Dr. Stanley.)

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

(Applause.)

DR. SPITALNIK: Thank you so much for this incredibly comprehensive and clear presentation and also really giving voice to how Medicaid is really a public health program. So thank you so much for that.

We'll open this up for questions and we will start with the MAAC.

Dr. Whitman, please.

DR. WHITMAN: Thank you.

Bonnie, it was a great presentation. I'm pleased to interact with many of the dental directors throughout the country in my position with the ADA. In New Jersey, I will tell you, Bonnie is well-respected. She's easy to get ahold of. And that's not just me talking, that's the Dental Society, that's individual dentists. She makes it easy. But with that being said, it's a pretty hard job because she has to look and oversee what's going on. And you have 1,800,000 people, potentially, patients here in New Jersey.

Now, when she showed a slide of the

Healthcare Effectiveness Data and Information Set® (HEDIS) scores, and it said, if you look at the 2 to 3-year-olds, it said 46 percent actually had visit during the year. That didn't mean that they got real preventative services or, quote, real dentistry or complete dentistry. They were seen. I don't think that's a good measure of how well we are doing in any state when you measure it that way, that's number one. When you look at the slides, of the number of people that are actually participating, providers in Medicaid, and you saw the number 2300. That sounds like a lot because in New Jersey you have 7,000 dentists who have a license to practice in New Jersey. But dentists in Medicaid come in and out of the system. And that is not an accurate reflection of how many are really seeing patients.

When I talk to the MCO dental directors, they tell me on average they think actively they have between 15 and 20 percent of the dentists who participate on an active basis. Now, when you looked at that slide and you said it showed something like over 900 people were producing more than $50,000 worth of dentistry, that wasn't necessarily in one office, because they could be working in one office down here one day a week and another office as a specialist. So

it's not a great reflection on how well we are really doing in New Jersey.

In addition, I have always maintained that -- I know all the dental directors here in New Jersey with the different MCOs, and they're great people. But the system doesn't work very well because it is very hard to be credentialed. It still takes too long. I know we were promised now in 2018 that's going to happen, but it takes someone many months to get into the system. It doesn't happen that way in the private sector, on the private side of insurance.

In addition, what happens -- and in New Jersey, I'm the first to admit we have a full range of services, which is great; better than most states, by far. But there are some services that are 50 percent of the time -- and I'm going to use that number and I'm not far off -- that are denied almost automatically. Periodontal services. I get a call almost every day, working with New Jersey Dental Association, about services that have been denied. And it's almost routine. And the reason it doesn't show up on the grievances and appeals, because most dentists are not going to do it, go for a second time or a third time. There are four different levels of appeal. So it's not a fair reflection of what's happening. I just don't

think the services -- there are services on paper there. And if you really push -- look, if I call up and ask someone to authorize it, they authorize it because I know I'm honest and we're going to try to do a good job. But the average dentist is not going to call up. And they shouldn't have to.

And I think Bonnie is right in asking that everybody's working with the same criteria, all the different MCOs. For a long period of time, that didn't happen. Everybody's got a different standard and it's pretty hard to talk to some of those people. Other than that, I thought it was a great presentation.

Thank you, Bonnie.

DR. SPITALNIK: Thank you very much.

Beverly Roberts.

MS. ROBERTS: Thank you. Excellent presentation. I was especially interested in all the activities for children, for young children, that you're doing that I was not aware of. So I agree with everything that Dr. Whitman just said completely, and I just wanted to add a couple of additional points of concern, specifically from the vantage point of an advocate for people with intellectual developmental disabilities (IDD), including autism.

And this is anecdotal of things that I hear

from families. But sometimes you've got a dentist listed in the directory not taking new patients or has no experience with somebody with autism or other significant challenges. And so that's frustrating. And what tends to happen is if families can't find someone relatively easily, they just wait and they don't get the kind of ongoing preventative care that we all would want them to have until something significant happens, which is more problematic, more expensive.

And just as Dr. Whitman was saying, if somebody comes to him, he can go through what has to be gone through to have something approved. If somebody comes to me, I can go to the specific Medicaid MCO, and they will get access to a dentist. But it shouldn't have to be that way. And then I worry about all the people that didn't know to come to me or other advocates in the system to try to get them the services that they need. So that's something that is an ongoing concern.

The other thing is I just want to give a plug for the Boggs Center and the focus group, the Medicaid Dental Care Focus Group that's going to be held at the Boggs Center later this month, which is an opportunity for family members who have an adult who has a developmental disability (DD), including autism,

between the ages of 21 and 60, I believe, will be given an opportunity for this focus group for family members to talk about the experiences they have had specifically. with Medicaid dental care.

And then the last thing is the clinical criteria that has been discussed, do you know whether there is anything in there or should there be that would relate to people with special needs and additional services that they might need? I don't know anything about the criteria.

DR. WHITMAN: There is. I know Bonnie is working on that, because we've been doing that because certainly in terms of frequency and services, you will find that with special needs patients, we find it easier to get things approved. We really do, in general.

MS. ROBERTS: Because the idea of anesthesia, some people do need general anesthesia for dental care. That's, obviously, expensive. Fewer dentists that do that, but that is also a concern that we have, that that be available. Thank you.

DR. SPITALNIK: Anyone else?

DR. STANLEY: I want to thank you for your comments and make sure that you understand that I do understand your comments and your concerns, and that

just gives us more work to do.

DR. SPITALNIK: Thank you so much.

Could I ask you also to comment on the workforce issues in preparing dentists in New Jersey and the supply of dentists, both through the dental school and attracting people and things that might be done to stimulate, not only more personnel coming into the field, but also more responsiveness to participating in the Medicaid program.

DR. STANLEY: That's a lot. So a lot of it is probably going to be driven by the cost of a dental school education and that versus what they can earn as a dentist, either in a private office that accepts commercial plans, as well as in a practice that accepts any of the NJ FamilyCare managed care organizations. But I think that the bottom line is it's who you are as a person and what you want to do for your community and the society that you live in. Because as a decision, I could have been a clinical dentist, but I have found the work that I do rewarding in working with dental community, in working with the individuals that we serve, and trying to wrap my mind around the opportunity to not only have a benefit and a program, but to see that it actually works the way you want it to work. So I think that while it's -- you can go to

dental school, surely, but if you don't have the mindset to be public health grounded and to want to actually see the opportunity to practice as the ability to reduce disease and disparity, you may not be driven to work with some of the communities and address it as a disease. You may see it as a way to make a living. And if it's more than that, then you will consider going into public health.

DR. SPITALNIK: Thank you.

Wayne, do you have a question.

MR. VIVIAN: Yes. Bev, or to anybody, actually, even out in the audience, does anybody know of any training programs that helps patients or Medicaid recipients become effective self-advocates if there's denials of services? Like, can the dentists tell, "Look, I don't have the time to keep appealing this, but if you want to pursue it, you pursue it," and possibly give some buzzwords and some suggestions on ways they could get their appeal approved?

DR. WHITMAN: I'll take that one.

In our office, we do the initial appeal. And then we find that we have actually better success in a large practice if we tell the patient to then call a second time. And I will tell you what I found, in honesty -- the MCOs won't like this -- but if you keep

appealing, truthfully, they don't want to end of going to court. It's too costly for them, because that's the last level of appeal. So in a good percentage of the cases, you are likely to find success. Let me say it that way. So we do tell our patients, and we do appeal for them as much as we can. But, you know, it's a logistics problem, too, to be quite honest with you. But from the patient side, I think the answer is if you are persistent, you are more likely.

The one thing in reference to Dr. Spitalnik's question about dentistry and getting more people into the system, you know, there was a time when if you worked within the Medicaid program there was loan redemption. And that was a wonderful thing. That was a wonderful enticement for young dentists to come in. And it made it very easy for me to hire young dentists who wanted to work in the inner-city. My office was in the inner-city of Trenton at that time. But then what happened, with the advent of the Federally Qualified Health Centers (FQHCs), they decided in order to help the FQHCs, they were going to give them loan redemption but take it away from the private sector even if they were seeing a huge percentage of Medicaid. That, I think, was a terrible mistake because, in the end, you lost people that were

willing to go into the Medicaid sector.

DR. SPITALNIK: Thank you for that.

Yes, Carol.

MS. GRANT: I think Wayne's question is a good one. It's one of the reasons why we did such an extensive presentation. We have many advocates in the audience. We want you to understand the benefits so you can help the people you work with understand the benefit and their right.

I mean, the plans are obligated to help their members to go through an appeal process. But the issue of patient self-management is an important one. And I think we have to work together with the advocate community to figure this out. Some people simply don't have the skill to do it or they're afraid to do it. And I think through trusted partners, they need to learn how to do it. I think it's a very good point.

DR. SPITALNIK: Thank you.

You're name?

MR. CASEY: Kevin Casey, New Jersey Council on Developmental Disabilities.

I want to support what both Dr. Whitman and Beverly were saying.

I talk to a lot of families with developmental disabilities. And in that group, I can

barely go to a group and talk to a group of families or a group of individual where the issue of dental care doesn't come up and the very difficult issues a lot of those families face getting dental care. I will tell you that it's not a New Jersey problem alone; it's a national problem. But I think we're required to find a way to solve it in New Jersey. So I would suggest that one of the things we might do is put together a group of people. Call it whatever you want, a task force, planning group, whatever, of advocates, people from the Department of Human Services, families who have experienced this problem, and do some planning as to how we might resolve the very serious problems families and people with developmental disabilities are having in terms of getting dental services. I think there are solutions. I think we simply need to look for them and work on them.

One other thing I'd add to that. I don't know if this is true in New Jersey; maybe you can tell me. The problem in a lot of other states with the low percentage of dentists signing up to accept Medicaid is that the payments that they get for Medicaid is not near what they get from third-party insurance, and they just can't afford as a business to do that. I don't know if that's a problem here or not, but it is in

almost every other state I'm aware of. And we probably need to look at that, too.

DR. WHITMAN: It is a problem in New Jersey. And what happens is we think about it -- and I think the dynamics are changing. I think the dental schools are realizing this.

Let's talk about New Jersey. Twenty percent of the population is covered by Medicaid, 33 percent of the children are covered by Medicaid, and yet 42 percent, I think, last year were to Medicaid families. So what's out there in private practice has changed.

Now, periodontists as a group, in general -- not all -- in general, realize this. And that's why you see the percentage of pediatric dentists taking patients has grown over the years. It hasn't hit the adult population yet. And the people here are 100 percent correct. It is very difficult for an adult patient to navigate -- I don't care whether you have special health issues or not -- to navigate that system because the procedures take longer. In comparison, because of the time of the procedure, the remuneration is much less and it is very difficult. And that's why you see the growth of large practices because efficiency makes it a little bit more palatable.

DR. SPITALNIK: Thank you.

Yes, please.

MR. WATSON. Hi. Heather Watson, Horizon NJ Health. Just to address your issue with regard to helping members navigate the system, we have emphasized that our customer service be very versed in how to do just that. But we have to get the members to call. The first line is for all the members to call then the member services representative should be able to walk them through a self-appeal or any type of self-referral. That's something that's been emphasized by the State for us to encourage, and we've been making efforts to do that; and, to make it more clear in the literature. I know a lot of the members don't read the literature or don't keep literature, but they have their card. And the first thing should always be to call member services and specifically say that they want to appeal a denial. That will get the ball rolling as the start of the process. Members are able to request appeals verbally. Also, we have member advocates that will call them back if they say they don't understand the process and need someone to assist them.

DR. STANLEY: And I would just like to add that if your group wants to get together that you

should also consider someone from the dental school, because the challenge is that it is not a dental specialty. So anyone who makes a decision to treat populations that have intellectual disabilities (ID), it's because they, on their own, have hone those skills to be able to work with that population.

DR. SPITALNIK: What I would add to that, though, there is a specialized dental clinic at the Dental School in Newark, and they are, I think, having some impact on creating that, but it's small.

DR. STANLEY: Right. Someone from that group probably would be best.

DR. SPITALNIK: Josh, and the man in the back.

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

First of all, thank you for an excellent presentation and your commitment to helping Medicaid beneficiaries for their dental needs. I have questions in two areas.

One, it sounds like this project of developing the uniform criteria is a very good project and will impart some consistency to decisions. But I wanted to ask you how does that balance with -- you spoke earlier about no blanket rules and treating the

whole patient and medical necessity. So how do you balance those things, number one?

Number two, how will a uniformity in criteria relate to what's in the regulations? And part three of that question is, when you have this proposed plan, which it seems like it's coming very soon, I wanted to know if you are planning to put it out for public comment so that consumers and Medicaid beneficiaries would have some opportunity to comment? And if you are not, I would encourage you to think about doing that.

DR. STANLEY: Thank you. So when we say things are case-by-case, that means it's on an individual basis of what's presented to you clinically. When we speak about clinical criteria, we are saying, for example, what has to be present for you to consider approving a root canal? So if the clinical criteria says that in order for a tooth to be considered for a root canal, it has to have more than 50 percent bone support, it has to be an occlusion with other natural teeth or with an artificial denture tooth, it has to have at least -- I'm trying to think what the regulations say. It has to have a certain amount of natural tooth structure remaining, and the tooth has to be restorable. So in other words, if you get a denied

root canal and then we look at the tooth, the tooth has 30 percent bone remaining, which means that this is too technical in other words, so your teeth are anchored in bone. The bone should come up pretty close to where the crown or the visible part of your tooth is in your mouth. If you have bone loss, then you're going mobility. The tooth is going to be in traumatic occlusion and it probably isn't going to have a good long-term prognosis. So the clinical criteria is not for the whole, it's for specific procedure codes.

So if you're reviewing a request for a root canal, and the root canal has more than half of the bone is gone, the tooth has very little clinical crown and is not going to have a good long-term prognosis for a crown to keep it in place, then the decision would be that they don't meet that criteria, the tooth should be extracted. Or it's going to be, well, the tooth has adequate tooth structure, it's got great bone support, it should be approved. If it's five teeth with that request that have adequate bone support, then five teeth should be considered for a root canal. That's what the clinical criteria is saying, more or less. It's not looking at the complete treatment plan, but it's applying the policy and the regulations as set forth in the New Jersey Administrative Code into how

you look at every service that's being requested. Did that answer your question.

MR. SPIELBERG: I think so. But I wonder will there be an opportunity for an individual to say, "Well, I don't quite meet that criteria, but I think I'm equivalent to that because of?"

DR. STANLEY: They can, or their dentist can. That's what I'm saying. By having that clinical criteria, your treating dentist notes what the reviewer is weighing that decision against. So they have an understanding of, well, it's a good shot that this will be approved so let's ask for it because it's within reason. It clearly says that this is what has to be met. It meets it. So we can consider that as a treatment option for you.

MR. SPIELBERG: So I just want to make sure. Having the criteria is helpful, but I think it helps both the director and the patient if there is some, even if you don't meet the exact criteria --

DR. STANLEY: You always have that opportunity, through medical necessity.

MR. SPIELBERG: And the other part of that was the public comment.

DR. STANLEY: Right. We'll take that back to the Division.

MS. GRANT: Duly noted.

MR. SPIELBERG: And then just the one other area Dr. Whitman mentioned -- there's some services that we see regularly denied, and that's often the prosthodontic services. So if you get to that situation where you have to remove the teeth, it's easy to remove them, but in terms of getting prosthodontic options approved, I think there are three options, denture, a bridge, or an implant. And for the denture, there is a rule that you must -- as long as you have eight posterior teeth?

DR. STANLEY: The clinical criteria will spell that out a little bit better. But, yes, it's looking at how -- as I said, when you're looking at the whole member, you're looking at their occlusion. So it may not necessarily just be that their posterior teeth are closing together, how are they closing together? Can you function with it?

MR. SPIELBERG: Right, but what we see is that it often leaves people just with missing teeth because they don't meet the criteria to get the denture, and getting the bridge and the implant is very difficult. So I wonder -- one of the things you mentioned is New Jersey is in the group of expansive states, which is great. But I wonder if, particularly

a prosthodontic, whether you could consider a more expansive policy perhaps by looking to some of these other states to see how they treat better.

DR. STANLEY: Okay.

DR. SPITALNIK: Thank you.

One more question in the back.

ALEX: Alex from Liberty Dental Plan. First I want to applaud the Division for implementing the uniformity. I have a difficulty with some providers -- their interpretation of requests. I think that's a great idea what Dr. Whitman mentioned. Many providers improperly bill. And the time period to get a doctor credentialed takes two to three months. By the time they get credentialed, the doctor is probably finding another opportunity somewhere else because they don't have the ability to initially start working at that practice.

And another comment that I want to mention -- I see that we, as an administration, put in a lot of effort at DMAHS or the MCOs to try to get the providers to provide the best dental care. However, what is DMAHS doing in regards to improving the dental health consciousness of the members? Because what I get a lot from when I'm recruiting, I try to recruit about 750 providers. Out of those 750 right now, I have a

handful that are interested and they want a higher fee for the most part. And most of the patients don't show-up to their appointment. So that's a huge challenge for the providers to encourage the patients to come into the practice to provide preventative services. When they submit a treatment plan for a filling, in that six months, it became now a root canal. Now the cost of that particular filling was something that could have been addressed with a filling. Now it's a root canal, post, and a crown. And sometimes they fail to come in for a crown. Now the tooth became an extraction. I just want to know what is DMAHS doing in regards to increasing the dental health consciousness of the members so that way they can come in the practice and actually get their appointment for the fillings.

DR. STANLEY: Thank you for your question. So just a quick answer, I would say that if that patient is a member in one of the MCOs, a large part of that responsibility is on the MCO to outreach and work with their members when they're aware that their member is not keeping appointments. So as a provider, the provider would need to let the MCO know, I have been tracking this number of your members that have been breaking appointments.

The other side of that is, as I mentioned, we're doing a partnership with a grass roots organization, and that is to help us to identify individuals in the community. We're looking at different organizations. We know the ones that are out there that we work with. So we know Head Start, working with them in terms of outreach and education on keeping appointments, making appointments, why baby teeth need to be treated. You don't just ignore them because they fall out. So a lot of this is going to be looking at other partners because we've been doing it for a long time, but it doesn't appear that hearing it from the State is going to be the only messenger they need to hear from. So if they hear it from their Head Start teacher, if they hear it from the Women, Infants and Children office, if they hear it from Meals on Wheels, if they hear it from other folks that provide services to them, that may be another way of helping them to understand the value of their benefit and the opportunity that they have to improve their oral health.

DR. SPITALNIK: I very much appreciate the question, thank you.

Dr. Stanley, thank you so much for this presentation and everything you do.

(Applause.)

DR. SPITALNIK: We now turn to a series of informational updates, starting with Director Meghan Davey on NJ FamilyCare.

MS. DAVEY: Good morning. I'm going to provide you with a quick update. I don't have too much. I know we have a much longer agenda, so I'll be brief.

(Presentation by Ms. Davey.)

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

DR. SPITALNIK: Thank you so much.

I know that one of the things that has been of concern across the community were the proposed changes in the American Health Care Act that was not actually formally voted on and what kind of planning or what kind of informational update do you have from the National Medicaid Directors. I think there's a lot of concern that while there isn't new legislation that there are many administrative opportunities for changing the Medicaid program at the federal level.

MS. DAVEY: Sure. I think at the last meeting I discussed the future of Medicaid, including

what we were tracking. So right now, it's business as usual. The Centers for Medicare and Medicaid Services (CMS) had a call with the National Association of Medicaid Directors to talk through the CMS letter that was sent to all the governors. That was laying out, at a very high-level, a lot of flexibility to states and a commitment to working with states on their waivers, trying to expedite waivers, fast track waivers and fast track State Plan Amendments, which was good to hear from that perspective. So we're watching any new developments really closely. And we'll keep you up to date as we get information.

DR. SPITALNIK: Thank you.

Other questions or comments for Meghan?

Questions from the public.

MR. SPIELBERG: One comment. Congratulations on getting 500,000 since the expansion. We always say we're close 500,000.

MS. DAVEY: Yeah. Thanks.

DR. SPITALNIK: Thank you for that.

Other comments or questions?

Thank you so much. And clearly an agenda item for our July meeting.

I will ask one more question. In the waiver approval, the home and community-based services

(HCBS)waiver, what we call the Community Care Waiver (CCW) is now included in the 1115.

MS. DAVEY: It's the authority to move it to the 1115 is the request, but no actual change.

DR. SPITALNIK: So will that be happening? And is there a timeline for that?

MS. DAVEY: So that is a ask of the renewal. So I can't speak for CMS, but that is part of our negotiation to move the authority to 1115.

DR. SPITALNIK: Thank you for that clarification.

We'll now move to the Managed Care Final Rule (MCFR), and call on Carol Grant, the Deputy Director of DMAHS.

Carol, good morning.

MS. GRANT: Mine is not going to be a long presentation, but I do have some good news. We have been advised by CMS that the January 2017 managed care contract (contract) is approvable. This is step one. We are now in the process of having the plans sign-off on the contract. It will then go back to CMS, and they will issue a final approval. And then the contract can, in fact, be posted publicly on the website, as we have done in the past.

I'm just going to do just a couple of

highlights here, just to remind folks because I'm going to concentrate on what's in the January 21017 contract related to the MCFR.

(Presentation by Ms. Grant.)

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

DR. SPITALNIK: Carol, thank you so much.

Any questions or comments?

Theresa and then Beverly.

MS. EDELSTEIN: Thank you, Carol, for the presentation.

Just a question. We've heard a lot about the administration in D.C. giving CMS the instruction to review all regulations that are going to become effective. There have been some delays in effective dates already issued on regulations not related to Medicaid at all. Have you heard anything from the National Medicaid Directors that this possibly could be delayed in term of implementation, especially in light of all the flexibility conversation?

MS. DAVEY: I think in the governor's letter, they talk about the MCFR and they talk about the statewide transition plan as potentials for areas

where -- I don't think for these current contracts, but there is potential for flexibility for states to have more time.

MS. GRANT: I think that what we're hearing, and Meghan talked about it, we're on weekly calls listening to the National Association of Medicaid Directors (Association). The good news is that the Administration is talking to the leadership of that Association and looking at places where states are asking for flexibility. So they seem to have been receptive to that. There are states that are not in as a robust condition as New Jersey, so they may need more flexibility in terms of timing and everything else and it's, I guess, to be determined.

MS. EDELSTEIN: Okay.

DR. SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: Thanks, Carol, for that presentation. I have two quick questions.

You talked about the change in appeals and grievances starting July 2017, that there will be one level, and then you mentioned something about robust. Could you give a little bit more information about what that one level will look like?

MS. GRANT: Well, we haven't fully vetted it

internally. We have drafted it. It's going to have to be the internal level of appeal at the health plan. I think there were many comments to CMS and yet they preserved that level. New Jersey had two levels. We're not going to be able to do that. We have, in fact, I think, discussed with CMS whether or not there was any ability to waive any of that. There is not.

I think in future MAAC meetings we'll be going through this in quite extensive detail so that we can make sure that people really understand these changes and how to make use of all of their appeal rights.

MS. ROBERTS: And hopefully, since this goes into effect in July and our next MAAC is July, if we could have that on the agenda for July, that would be terrific.

And then there was one other question. When talked about the "in lieu of services," that was one of the first things that you said, could you just give an example of how what that would look like for somebody who has a developmental disability, so I can understand it a little bit more.

MS. GRANT: It's an opportunity for flexibility and looking at alternative ways of implementing a service need that may not be specific to

the benefit package.

MS. DAVEY: I think we can probably provide you something.

MS. ROBERTS: Just as an example, so I can understand. My thinking would be if it's something helpful and extra, that's terrific. If it could be interpreted in some way as providing less than what they would otherwise get, that would be my concern.

MS. GRANT: I don't think that's the intent.

MS. ROBERTS: Okay.

DR. SPITALNIK: Thank you.

Any other questions of the MAAC?

Members of the public?

Seeing, none.

MS. GRANT: Could I just make one other comment?

DR. SPITALNIK: Of course. Please.

MS. GRANT: As we've done in the past, we have worked with Disabilities Rights of New Jersey (DRNJ), we've worked with Legal Services in terms of the appeals process. So we'll make sure that they remain in the loop.

DR. SPITALNIK: Thank you so much, Carol, as always.

I'm calling on Laura Otterbourg, the Acting

Director of the Division of Aging Services. Laura is going to present on Managed Long Term Services and Supports (MLTSS). And I'm delighted that her presentation includes many of the concerns that were raised previously about behavioral health and MLTSS. Laura, thank you and welcome.

MS. OTTERBOURG: Thank you.

(Presentation by Ms. Otterbourg.)

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

DR. SPITALNIK: Thank you so for this data.

Going back to the slide, I think it's one or two slides ago, on MLTSS developmental disability (DD) recipient service utilization. One of the concerns that I want to raise is the number of people with developmental disabilities in nursing homes. There appears to be from Fiscal '15 to '16 a dramatic increase in the pay code, and that may be the fact that more people have transitioned to MLTSS, but the whole issue of people with developmental disabilities under the age of 64 living in nursing homes, we've seen that on the rise in New Jersey. That's a national trend, and it's a trend of great concern. So this may be an artifact of

moving into the system, but I think that's an issue we would like to keep track of and put on the agenda.

MS. OTTERBOURG: Okay.

DR. SPITALNIK: Are we utilizing nursing facilities when there could be home and community-based options that were built around an individual even with a lot of medical complexity?

MS. OTTERBOURG: Okay.

DR. SPITALNIK: Thank you so much for this data.

Beverly, questions.

MS. ROBERTS: I just wanted to say thank you. I really appreciate this information.

MS. OTTERBOURG: Okay. Great.

DR. SPITALNIK: Thank you.

No other questions front from the front.

SPEAKER: In addition to the question about the population of people with development disabilities in nursing homes, I would also ask for information and some insight into the population of people with traumatic brain injuries that are in nursing homes. We have a number of clients who, through the care management, are not being served in home and community-based settings with supports that would be available and instead are being placed in nursing

homes. So that's another population I would like to echo the concern on.

MS. OTTERBOURG: They're being placed in nursing or CRS facilities?

SPEAKER: Nursing homes.

MS. OTTERBOURG: Okay.

DR. SPITALNIK: Phil.

MR. LUBITZ: I just want to say I appreciate the a behavioral health (BH) slides, but I just want to comment on the interpretation of the BH slides. So my quick calculation indicates that only about 2 percent of the people who are in MLTSS are receiving BH services. And if you look at this slide in particular, you can see where most of the money goes, right, or more than half of the dollars spent, inpatient care, and way down and look at outpatient and mental health clinics, we're seeing about 26,000 as opposed to about a half million. So we can really see unbalance and it really makes you wonder how robust our BH services are in MLTSS.

MS. GRANT: You know, the thing is, though, that it's slides like this that will begin to point out where we need to strengthen.

MR. LUBITZ: I appreciate that we start to look at the information.

DR. SPITALNIK: Thank you.

Other questions?

Laura, thank you so much. And again, let me echo the thanks for beginning to drill down further in the data as basis for understanding and also Bill's point of hoping to shift to more community supports. We now turn to an update on Mental Health Transition for Fee-for-Service (FFS), and we welcome back Roxanne Kennedy, Director of Behavioral Health Management for the Department of Human Services. Thank you.

MS. KENNEDY: Thank you.

I'm here to talk about our FFS transition, the Mental Health FFS transition that began in January of '17 and continues July of '17 and some programs end January of '18. And so I'm just providing an update of where we are today.

(Presentation by Ms. Kennedy.)

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

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

MR. VIVIAN: For the CSS and providers, we had to send in our first rounds of IRBs. Do we start

to bill for those units yet, or would NJMHAPP, or do we wait until it's up and running before we start billing for those units?

MS. KENNEDY: Can I get back to you on that? I have to check.

DR. SPITALNIK: Kevin.

MR. CASEY: Kevin Casey, New Jersey Council on Developmental Disabilities.

Actually, this is a more general question. I'm wondering if we can get a similar report on the transition of DD services to FFS at the next meeting, or something of that nature?

DR. SPITALNIK: Thank you.

Paul.

MR. BLAUSTEIN: Paul Blaustein, New Jersey Council on Developmental Disabilities.

Could you expand upon your comments on cash advances?

MS. KENNEDY: Sure. We're allowing providers -- we did in January 2017 -- two months cash advance on what had been 1/12 of their contract, so it would be two months or 1/12 of what they had before. Providers need to begin paying back at the third month and providers have until the end of the fiscal year to return the payment.

DR. SPITALNIK: Other comments or questions.

Thank you so much.

That brings us to the end of our agenda.

Is there any new business that people want to bring up?

And what we do at this time is to identify elements that we have noted on the agenda for our next meeting, which will be July 20, 2017. So working from the last to the first, we have a request for a similar presentation on the transition to FFS in the developmental disabilities system; Wayne's question about reimbursement. We are interested in an update on the changes in the appeals and grievances process. We hope by then to have a presentation on the changes in the new contract. Again, the issue of credentialing has been raised; this time in the context of the pace of credentialing, particularly around dental providers. And, of course, the continuing monitoring of changes in the Medicare program nationally and their implications for New Jersey.

Is there anything else?

Beverly.

MS. ROBERTS: Maybe an update on what's happening with LogistiCare or another vendor to handle transportation.

DR. SPITALNIK: So transportation update.

And, again, some of these will be amenable to the next meeting's agenda because we'll have the information and we can accommodate the number of items in the agenda, but we will keep them moving forward. Having no other business, do I have a motion to adjourn?

MS. ROBERTS: Motion to adjourn.

DR. SPITALNIK: Beverly.

MS. EDELSTEIN: Second.

DR. SPITALNIK: Second, Theresa.

Thank you all. Thank you for the excellent presentations. And good spring, good early summer, and we look to seeing you in July. Thank you.

(Meeting adjourned at 12:23 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 compressed transcript of the proceedings as recorded.

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