# 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 20, 2016
10:00 A.M.

FINAL

MEETING SUMMARY

**MEMBERS PRESENT:**
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Mary Coogan
Dennis Lafer
Dot Libman
Wayne Vivian
Sidney Whitman

**MEMBERS EXCUSED:**
None

**MEMBERS UNEXCUSED:**
None

**STATE REPRESENTATIVE:**
Meghan Davey Director
Division of Medical Assistance and Health Services

Transcriber, Lisa C. Bradley
THE SCRIBE
6 David Drive
Ewing, New Jersey 08638
(609) 203-1871
the1scribe@gmail.com

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

**ATTENDEES:**

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| Tom Pyle | Parent |
| Evelyn Liebman | AARP |
| Linda Robayo | Sunovim Pharmaceutical |
| Christopher Bruette | Aetna Better Health New Jersey |
| Cheryl Reid | Aetna Better Health New Jersey |
| Dan Keating | Alliance for the Betterment of Citizens with Disabilities |
| Willianm Healy | Alman Group, LLC |
| Alison Dorsey | Amerigroup |
| Brian Atkisson | Association of New Jersey Chiropractors |
| Matthew Minella | Association of New Jersey Chiropractors |
| Colleen McLaughlin | Boggs Center Rutgers University |
| Tom Grady | Brian Injury Alliance |
| Kitty Lathrop | Burlington County Board of Social Services |
| Renee Murray | Camden Coalition of Healthcare Providers |
| Natassia Rozario | Camden Coalition of Healthcare Providers |
| Shabnam Salih | Camden Coalition of Healthcare Providers |
| Mark Humowiecki | Camden Coalition of Healthcare Providers |
| Jennifer Farnham | Center for State Health Policy |
| Mary-Catherine Bohan | Community Care Behavioral Health Organization |
| Kimberly Devinney | Community Care Behavioral Health Organization |
| Kimberly Salomon | Community Health Law Project |
| Lisa Eisenbud | Get Going, LLC |
| Chrissy Buteas | Homecare Hospice Association of New Jersey |
| Karen Brodsky | Health Management Associates |
| Lillie Evans | Horizon NJ Health |
| Heather Watson | Horizon NJ Health |
| Joshua Spielberg | Legal Services of New Jersey |
| Carol Katz | Katz Government Affairs |
| Gwen Orlowski | Legal Services of Central New Jersey |
| Christine Fares Walley | LIFE St. Francis |
| Melinda Martinson | Medical Society of New Jersey |
| Cynthia Spadola | Mental Health Association of New Jersey |
| Jennifer Dingler | Monmouth County Board of Social Services |

**ATTENDEES:**

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| Stacy O'Conner | Monmouth County Board of Social Services |
| Mary Abrams | NJ Association of Mental Health and Addiction Agencies |
| Debra Wertz | NJ Association of Mental Health and Addiction Agencies |
| Kevin Casey | NJ Council for Developmental Disabilities |
| Paul Blaustein | NJ Council for Developmental Disabilities |
| Melissa Chalkere | NJ Foundation for Aging |
| Grace Egan | NJ Foundation for Aging |
| Tyla Housman | New Jersey Health Care Quality Institute |
| Anh Phan | New Jersey Health Care Quality Institute |
| Colleen Woods | Greater Newark Accountable Care Organization |
| Michael Mahoney | Optum, Inc. |
| Karen Shablin | Optum, Inc. |
| Sonia Delgado | Princeton Public Affairs Group, Inc. |
| Mary Kay Roberts | Riker, Danzig, Scherer, Hyland & Perretti, LLP |
| Joseph Jaeger | Robert Wood Johnson Barnabus Health |
| Alexander Puma | Robert Wood Johnson Barnabus Health |
| Kathleen Lockbaum | Salem County Board of Social Services |
| Steven McRae | Sequenom Labs |
| Linda Robayo | Sunovion Pharmaceuticals |
| Gregory Paulson | Trenton Health Team |
| Vincent Ceglia | UnitedHealthcare |
| Susan Hazen | UnitedHealthcare |
| Michael Simon | United Healthcare Community Plan |
| Zinke McGeady | Values Into Action NJ |
| Cort Adelman | Wellcare |
| John Kirchner | Wellcare |
| Lisa Knowles | Wellcare |
| David Weber | Xerox Government Health |
| Nicole McKnight | Centers for Medicare & Medicaid Services |
| Michael Simone | Centers for Medicare & Medicaid Services |
| Maria Varon | Centers for Medicare & Medicaid Services |
| Dawn Apgar | NJ Department of Human Services |
| Frieda Phillips | NJ Department of Human Services |
| Brian Francz | NJ Department of Treasury |
| Noah Glyn | NJ Department of Treasury |

**ATTENDEES:**

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| Jodie Flandinette | NJ Division of Medical Assistance and Health Services |
| Carol Grant | NJ Division of Medical Assistance and Health Services |
| Thomas Lind | NJ Division of Medical Assistance and Health Services |
| Valerie Mietke | NJ Division of Medical Assistance and Health Services |
| Pam Orton | NJ Division of Medical Assistance and Health Services |
| Mariam Rashid | 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 |
| Phyllis Melendez | NJ Division of Medical Assistance and Health Services |
| Terrie Whitfield | NJ Division of Family Development |
| Joshua Lichtblau | NJ Medicaid Fraud Division |
| David Drescher | NJ Office of Legislative Services |
| Robin Ford | NJ Office of Legislative Services |

DR. SPITALNIK: Good morning. I'm Deborah Spitalnik, and I'm delighted to welcome all of you to the April 20th meeting of the Medical Assistance Advisory Council (MAAC).

In accord with the New Jersey Open Public Meetings Act, adequate notice of the schedule of this meeting and the public notice and invitation to attend was transmitted to the Office of the Secretary of State and advertised appropriately.

I'm also obligated to let you know, as guests in the State Police Headquarters, that I need to let you know about an emergency evacuation procedure, which I have no doubt we will not need. But upon hearing the fire alarm or evacuation announcement, I need to ask you to quickly leave the building via the nearest exit and go to Lamppost No. 9 in the large parking lot. And once there, you will report to Meghan Davey and Phyllis Melendez who will check your name off of the attendance list and wait in the designated area.

Now that I have done the official business, my first piece of business today, before I introduce the MAAC and ask all of you to introduce yourself, is to extend to Meghan Davey, the new Division Director for the Division of Medical Assistance and Health



Services (DMAHS) our welcome and our delight that you are in this role. I think many of you have worked with Meghan over time. She has been with the Division of Medical Assistance and Health Services for over 17 years. She served as Policy Director and Chief of Operations. Many of us have interacted with Meghan in various capacities, including around the development of the Comprehensive Medicaid Waiver (CMW). And she also brings with her, as I think many of you know, tremendous experience in helping New Jersey integrate our services and benefits from the Affordable Care Act (ACA).

So welcome, Meghan. We look forward to working with you and supporting you and the Division's efforts.

(Applause.)

DR. SPITALNIK: So a review for those of you have been with us in the past and a welcome to people if this is your first meeting, we'll do a couple of things together. I will ask the members of the MAAC to introduce themselves. I'll then ask members of the public to introduce yourselves. That's not a time for statements, but rather to let us know, as my grandmother would say, with whom we're speaking. We will then go through our agenda, which has an approval



of the minutes, an informational update, and a series of presentations.

We've been fortunate in our interaction as a Council and as the larger community that we have not confined ourselves to specific limited periods of time when the public can provide input. We've been able to have a dialog around the issue at-hand that we're dealing with. But if at any time that started to become unwieldy or unfeasible time-wise, we might have to institute that kind of limitation. I hope we don't. I think we've all been enriched by dialog.

So members of the MAAC will introduce themselves. From a public health perspective, it's probably better that we not pass the microphone around, although I'm sure it's all allergies for everyone, as it is for me. When you introduce yourself, please do it clearly so Lisa Bradley, who takes our wonderful notes, can hear you. When you ask a question during the conversational part of the meeting, please identify yourself if you're not a member so that it can be included in the record.

So with that, I'll ask Dr. Whitman to start. We'll go this way and then we'll go to the public.

(Members of the MAAC introduce themselves.)

(Members of the public introduce



themselves.)

DR. SPITALNIK: Welcome, everyone. And as always, we're delighted to see so many people here.

Our first order of business is to turn to the minutes of our last meeting, January 20th. We have a draft. We need to review those, find out if there are any additions or corrections, and then I will ask for a motion for approval.

MS. ROBERTS: I have a small change correction. It's on page 35 and then the top of 36. There was a comment that was made by Ms. Orlowski, and Ms. Roberts is listed as the speaker instead of as Orlowski in those two places.

DR. SPITALNIK: Anything else from anyone?

Thank you, Bev, for that.

Do I have a motion for approval of the minutes?

MS. COOGAN: So moved.

DR. SPITALNIK: Coogan.

Second?

MR. VIVIAN: Second.

DR. SPITALNIK: Vivian.

All those in favor?

MAAC MEMBERS: Aye.

DR. SPITALNIK: Any objections?

Abstentions?

The minutes of January 20th are approved.

Our first item of business is a report by Dr. Lind for the provider credentialing process.

DR. LIND: As we began the construction of architecture of the new credentialing system and as we included the managed care organizations (MCOs) and sister agencies, it became apparent that we were going to need to build the universe of provider types. I'll remind you that we initially were going restrict the Phase 1 credentialing initiative to medical, dental, and behavioral health providers. But it became apparent that we were going to need to build the universe of all provider types, not just the ones that we were including because of the considerations that we were beginning to understand. It became also impractical to make distinctions between providers that would be included in Phase 1 and those that would be included in Phase 2, because some providers types straddled the line and it was very difficult to determine what would happen.

Therefore, two months ago we made the decision that we were going to merge Phase 1 and Phase 2 and accelerate the anticipated December 2018 time-frame for that to March of 2017. The previous Phase 1



Go-Live of June 30, 2016 was canceled, as it did not make sense to proceed with that. So we're going with a more ambitious agenda and I think one that makes a lot more sense in the long run.

We will now include all fee-for-service (FFS) and managed care provider types that will do business with Medicaid, including the non-traditional provider types. We have since completed a series of meetings which included our sister agencies, stakeholders, and the managed care plans -- so the managed care plans are the next phase. Sorry. And we're identifying subject matter experts and licensing entities and anyone appropriate to be part of the discussion of what it is that constitutes a credentialing standard for a provider type that have not yet had that defined. And I believe New Jersey is the first state that's going through this process. We're using fee-for-service provider types as our start, so we're using specialty codes, provider types, and New Jersey specific identifiers.

When that process completes, we're going to be cross-referencing those fee-for-service types with managed care service types. And, we are well into that process, as well. I anticipate that we're going to be starting the meetings where we actually group the



subject matter experts together and get them in the room and get the work done to determine what a credentialing standard is. And then on a rolling basis, we're going to have our contractor put that into codification. And so when we look at test runs and getting this into a system, we'll have that ready to go in a much shorter time than if we did it as a single lump process. But we're still anticipating -- and I just confirmed this two days ago -- that we're still on time for March 2017 implementation date.

And I'm happy to entertain questions on that.

DR. SPITALNIK: Thank you so much.

Any questions?

Sid.

DR. WHITMAN: In the end, if someone is with an MCO, is the managed care company going to be responsible for their credentialing?

DR. LIND: When you say in the end --

DR. WHITMAN: Well, after March 2017.

DR. LIND: No. That's the State's purview.

DR. WHITMAN: So then the managed care companies will no longer be responsible for credentialing?

DR. LIND: For credentialing. Contracting



is still, obviously, within the plans' purview. We're not taking any of that decision-making away, but the verification, etc, is all going to be state-owned.

DR. WHITMAN: Okay.

DR. SPITALNIK: Any other comments?

MS. BRODSKY: Karen Brodsky from Health Management Associates.

What is the difference between being a service provider-type and a managed care provider-type? Where would there be differences?

DR. LIND: Whether the provider chooses to participate with fee-for-service or with any one of our all of our managed care plans. The provider can be all six at this point.

Does that answer your question?

MS. BRODSKY: Yeah. I thought you were referring to their specialties.

DR. LIND: Oh. Sorry. The way that fee-for-service defines provider types is there's several different layers. And unfortunately, they don't match up at all -- well, they match up partially, but there's definite disconnects between the way fee-for-service defines a particular specialty or a particular type of provider and the way that an MCO would define that. We're going to be more of an

additive process in certain cases. But when possible, we're trying cross off those into a single entity. Either way, it needs to be all-inclusive because we're talking about the universe of all of them, so we're going to need to do the best job we can on that.

MS. BRODSKY: Thank you.

DR. SPITALNIK: Anything else?

Thank you.

What would be the next natural juncture to provide an update? Would it be the June meeting?

DR. LIND: The next MAAC meeting.

DR. SPITALNIK: Okay. Thank you.

DR. LIND: Happy to do that.

DR. SPITALNIK: Thank you so much. I know you have to get to another meeting.

We're now going to spend a significant amount of time in our agenda around the Accountable Care Organizations (ACOs) that are being established. And we'll start off with Tyla Housman. And Tyla's the Senior Director of the New Jersey Health Care Quality Institute (HCQI). She'll provide the introduction for us.

MS. HOUSMAN: Thank you.

DR. SPITALNIK: All these slides that are shown will be posted on the Division of Medical



Assistance website at http://www.state.nj.us/humanservices/dmahs/boards/maac/ so they're accessible to you after the meeting. Thank you.

MS. HOUSMAN: Thank you.

Good morning, everybody. I'm the Tyla Housman. I'm the Senior Director of the New Jersey Health Care Quality Institute. I lead what's called our Quality Improvement (QI) Collaborative, which is a learning network dedicated to re-designing our health care system using new payment models, delivery system reforms, and new community-based partnerships. Our members include the certified and non-certified Medicaid ACOs and all of their provider partners. We help to facilitate collaboration and share learning through workgroup meetings, webinars, and topic-specific workshops. We also serve as a liaison between the Medicaid ACOs, the state, and other dominate healthcare stakeholders.

(Presentation by Ms. Housman.)

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

MS. HOUSMAN: You're going to hear from each of those three communities today about the priorities



that they've established for their Medicaid populations and the progress that they have made so far.

First up, we've got Mark Humowiecki and Renee Murray from the Camden Coalition of Health Care Providers.

MR. HUMOWIECKI: Thanks, Tyla. Good morning, everyone. It's really nice to be here to be able to share some of the work that we're doing in Camden with everyone.

So for more than a decade, the Camden Coalition of Health Care Providers has been convening the local health care community in a model just like the one that Tyla described. We help write the ACO law so it wasn't surprising when it came to certify that we actually qualified because we were already a membership non-profit that brought together hospitals, primary care providers, social services, and the community at one table to work together.

Our hypothesis is that to deliver better care at lower costs you actually have more collaboration, not more competition within health care. We know that Medicaid costs are driven by a relatively small portion of patients with complex needs, but the system isn't currently serving very well. These complex patients generally have multiple chronic



illnesses, are more likely to have mental health and addiction issues, may have a history of trauma, live in poverty, may face social isolation, or be homeless. No single health provider or system in Camden is going to be able to provide all the services that those individuals with complex needs need. Instead, we need to bring together Medicaid providers and social service agencies at a common table and figure out how to work together to coordinate services and to build new models of services that better meet the needs of complex patients.

So the Medicaid ACO structure has been a very powerful platform in which to organize and modernize the local delivery system in ways that neither government nor managed care is equipped to do. Just because we sit within our geographic community, we're able to convene all the local stakeholders in a very intense way. We offer sort of a value there to those partners.

So I'm going to cover five different major ways in which the ACO model creates value for government, managed care, health care providers, and ultimately for the Medicaid beneficiaries themselves. Then I'll turn it over to Renee Murray, our Associate Clinical Director who will share the story of one of

our patients so you can see how that plays out in day-to-day real life.

So the first point is that the ACO creates greater connectivity between and among the many parts of the delivery system. We have nearly 40 organizations that are members of the coalition. Our Board is made up of key representatives from across all of those different healthcare stakeholders that I mentioned earlier. We came from a board meeting this morning. It's a really exciting place to have folks who traditionally see themselves as competitors -- we've got Virtua and Cooper -- sitting together at same table. They're not always getting along, but at this table they collaborate and they work together, and we have created a space for collaboration and innovation.

Twice a year we convene the Chief Executive Officers (CEOs) of all four hospitals in our coalition as well as the Federally Qualified Health Centers (FQHCs) to come together and talk strategy and do what do we need to collectively re-shape the system.

Each month, line staff from across all the stakeholders come together for citywide care management meetings where they share new resources, they conference difficult cases, and they become part of an organized community that works together and knows who



to call when you have a patient with a complex problem.

And just this month, the Coalition has launched a new online resource that can help to bring together the service community by having -- it's called Aunt Bertha. It's essentially the Yelp of social services, and it has brought together a library of all the different resources within Camden and 300-plus step-by-step protocols for accessing services. So it's one more way in which people, whether a consumer, a family member, a case manager, a hospital, or a program can go online, look up the services that a patient needs and be able to access those services.

So those are just a few of the ways in which we're creating more connection among the delivery system within Camden.

Secondly, the ACO invests in data to drive system improvement. You've heard a little bit about the health information exchange (HIE) that connects patient data. We have folks throughout hospitals, primary care, even in jail are accessing the health information exchange to get up-to-date clinical information to improve the clinical delivery, as well as to avoid duplication of services.

The HIE is also able to drive workflow so. That we can identify patients that have been frequent



users of the hospital and get to them while they're in the hospital to deliver a structured intervention.

On the research side, we brought together data from across sectors, health data, law enforcement data, education data, homeless data, to get a better, more rich understanding of how individuals interact with different systems and to start to design new programs to be able to serve high users of multiple system.

And just on Monday, we were part of an exciting program in South Jersey called the South Jersey Behavioral Health Innovation Collaborative, which has really been taking a deep-dive look at the behavioral health system in our region. And one of the major components of that was pulling together data from three counties all of the hospitals encounters, there are five major health systems in three counties, and analyzing them based on the behavioral health diagnosis and seeing -- identifying more than 800 people who have hit each of five different health systems, across five counties, and trying to understand their needs and build new systems to collaborate across those five health systems and new models that can better serve their needs.

The third thing that the ACO does is that it



really drives quality improvement. We have contracts with Medicaid Managed Care Organizations (MCOs), both United Healthcare Community Plan and Horizon NJ Health. Through those contracts, we cover nearly 40,000 Medicaid lives. We have quality metrics that we're measuring each month for each of the 15 practices that are working with our ACO. They're around reconnection to primary care, cancer screening, breast and cervical cancer, prenatal and postpartum care, patient satisfaction. So that data is being displayed to the practices, to the frontline, as well as their CEOs on a regular basis and driving improvements.

Our quality committee's developed a host of citywide initiatives. We do the patient satisfaction surveys, nearly a thousand last year; in-person surveys, where we're getting rich feedback that are helping to inform how we improve practices and access to primary care for patients. We've done something called the Seven-Day Pledge which incentivizes both providers and patients to reconnect to primary care as they're coming out of the hospital. We pay additional dollars to practices to spend more time and follow a structured protocol with patients who are coming out of the hospital to make sure their medication is being managed, make sure that all the additional services

they need are being well managed.

That has had a dramatic result over the year and a half that we've been doing our Seven-Day Pledge. We've seen the rate of people coming out of hospitals and getting into primary care within seven days go from roughly 17, 18 percent when we started to nearly 40 percent consistently now. And so that is starting to drive improvements around re-admission and really helping to deliver on the goal of keeping people out of the hospital if they don't need to be there.

Fourth, the ACO provides care coordination for complex patients. Renee will talk about one patient who we've worked with, a patient who's fairly typical in terms of the complexity of needs. Our nurses, community health workers, social workers, collaborate in a time limited intervention to try to engage them in a relationship, a healing relationship that motivates people, uses motivational interviewing and other behavioral health techniques to engage people in their own care, to empower them and connect them to the rich array of services that exist in the community.

And finally, the ACO is a platform for innovation. So as we do the care coordination, as we work with complex patients, we see that there are certain types of services that aren't available that we



need new models of care. So in Camden, we've gotten into housing and actually have launched a Housing First Initiative for complex high-need hospital users who are homeless. That has been a whole new set of work for us and for our partners. We're not doing it ourselves. We're doing it with our behavioral health and housing members in our organization. We've gotten a lot of great learning from that, and it's also had a dramatic effect on patient lives, as you'll hear more.

And we're discovering that there's need for a whole host of new innovative programs, whether it's Suboxone for opioid addiction, Project Impact for individuals with chronic illness and depression, ambulatory Intensive Care Units. For the most complex patients, there are a host of others yet undiscovered models of care.

The ACO community-based organization (CBO) creates this platform for all of these organizations with a lot of resources that come together, innovate, and try to fulfill on this promise of better care at lower costs.

So we're grateful to the State and to Meghan and Valerie and the folks at the Department of Human Services (DHS) for putting in the Governor's budget a million dollar investment for the ACOs, because that



will help us to be able to scale the programs and continue to fulfill the promise of innovation and community organization.

So at this point I'm going to turn it over to Renee to tell the story of one of our patients.

MS. MURRAY: Thanks so much, Mark.

Good morning, everyone.

"A place. I need a place of my own. I'm sick and tired of these streets and living like this. Church, God still loves me. Getting my health back on track. This is painful. Getting clean. I'm still using heroin and I want to get linked up to a program."

Those are direct quotes from our patient Angela who we have been working with for some time now. These direct quotes were from a conversation we had with her three years ago. And at that time, those priorities and goals that she was listing there in her quotes, the Coalition wasn't really equipped or had the tools and the resources to really help her accomplish the things that she was verbalizing the first time we met her. That was prior to the ACO, prior to a lot of innovation and collaboration of community partners. So three years ago we had this conversation with Angela.

So Angela is a 57-year-old woman, a Camden City resident. She's living with Chronic Obstructive



Pulmonary Disease (COPD). She's oxygen dependent, hepatitis C, asthma, depression, bi-polar disorder, battling a heroin addiction for 30-plus years using three to four bags a day, multiple overdoses, involved in the jail system, arrested multiple times for prostitution, homelessness, four years of housing instability which resulted in seven long-term instances of homelessness.

And the team met her. And the team met her when she was in the Emergency Department (ED). In the six months leading up to our working with her, she visited the ED 26 times and had one inpatient stay. So 26 ED visits in six months. It's a lot. Probably most of us in this room haven't been to the ED 26 times in our life, hopefully. So these quotes that she said, they're her priorities, they're her goals. So the team meets her. They meet her at the bedside, they meet her at this catalytic moment where she's in crisis. We're talking to her and trying to learn more about her. We're trying to start to build a relationship with Angela.

And from what Mark was saying, the tools of the ACO has given the opportunity for not only the Coalition, the staff, but also for the patients to really innovate and collaborate and has really moved

Angela through this intervention, through this workflow with some pretty staggering results.

Circle back to the HIE that Mark talked about, Health Information Exchange. That really led us to the Angela. It was the data that led us to her. It was the communication, the real-time data feeds that were coming in from the hospital systems that say, hey, Angela is sitting here in the ED. This is a great moment for us to go over and begin to build our relationship. So the Health Information Exchange and the data piece were driving us to meet her. That started the relationship.

Once the team started working with her, we had the prompt re-connection back to primary care provider (PCP) with the Seven-Day Pledge, so that allowed Angela to get back into her primary care doctor's office with accompaniment from our team to act as a support, to act as an advocate, to act as a model, to really have a good dialog and conversation with the primary care physician. And that really triggered the whole spiral of the intervention. It allowed the primary care doctor to really start to learn Angela's story, not only that Angela has COPD and Hepatitis C and she has asthma and needs oxygen, but what else makes up Angela. How about that she has been using



heroin for 30 years and it's something that she's been battling with and she has realized her desires to get clean, or that she was living in a rooming house where she rented a couch where the landlord rented every couch, sofa, chair, basement, room, anything that was rentable was rented out, and she was living in an environment with 20 other people who were using drugs. The tenants were using drugs, the landlord was using drugs.

We're painting the picture, we're starting to paint the picture, starting to tell the story of Angela to the primary care doctor. And the crucial part was that she re-connected back in those seven days which was helping her decrease her chances of going back to the emergency department.

In addition, because of the innovation and collaboration of the ACO, we were able to connect Angela to mental health services at South Jersey Behavioral Health. We were able to link her to a Suboxone treatment program. She was seeing a psychiatrist and a counselor. And it was really a testament to the ACO. It was a testament to having people sit around one table and, like Mark said, not compete but to collaborate and really become one collective dynamic force where we can all talk to each



other and have universal care plans and really have an idea of what Angela is doing, what is she working through, where is she today, what's the next step tomorrow, what are we all working towards together.

So all these pieces came together for Angela. And the outcomes are fantastic. She hasn't used heroin in over 60 days. She's on a Suboxone program. She has a very strong relationship with her primary care provider. She is seeing a counselor and a psychiatrist who is managing her medications for depression and bi-polar disorder. She was just housed on Monday into her own apartment that also comes with the services of a registered nurse and a caseworker for the entire duration that she's on this Housing First voucher.

I moved her in on Monday. And just seeing her in this new light -- I used to see her every day on the street, and that was normal. There was Angela, she was on the street on the corner that she was always on with her oxygen tank. And to be able to see her move from where we were three years ago -- and that's another thing. It took three years to get there. It wasn't just overnight.

Like I said, the three years prior to that, we really didn't have the collaboration. We didn't



have everybody around the table really working to one unified mission. But now that we do have that, this was the outcome. Angela is connected, she's in a stable housing environment, she has nurses coming to her home, she's on Suboxone, she's clean. We're having great conversations with her, learning more and more about Angela everyday, learning more and more about who Angela is as a human being.

And that's what the care team does, we use the core tenets of harm reduction, motivational interviewing, a holistic approach, to really not just focus on the medical, the history. It's very easy to read the history of the patient and say, "Oh, we know this patient, COPD, she probably smoked cigarettes, she needs oxygen." It's very easy to read that line of history, but it really doesn't give you the full piece of who Angela is. When the team, the care team is there learning about her, it paints the picture that allows us to go out to the other resources for other community partners and come together collectively and put a plan of action in place.

So I just wanted to share with you the story of Angela and how we went from three years prior to where we are now. And it is solely because of everyone around the table communicating, collaborating, and the

innovation that we have the opportunity to have at the Coalition with the ACO.

Thank you.

DR. SPITALNIK: Thank you.

(Applause.)

MS. HOUSMAN: Next up we have Colleen Woods from the Healthy Greater Newark ACO.

MS. WOODS: Thanks, Tyla. It's good to see all of my old friends. I'm a former colleague of the Department of Human Services, which is just a tremendous place to work and I'll never forget my time there.

So, I also would like to extend my thanks to Meghan and to Val for the support of the ACOs. Just really can't find a better partner than Medicaid. They are so willing to help us through all of these legal issues in terms of the implementation and data, sharing data, and all of the financing part. And we really appreciate your support and look forward to implementing something really remarkable in New Jersey.

I also want to thank my colleagues from Camden and from Trenton who are so supportive of Newark, because as you'll see from the Newark presentation, it's vastly different than Camden. So thank goodness we have Camden's early innovation. And



those of us in Newark who are just starting really at go are looking to Trenton and Camden to sort of guide us but also create something new. And that's what I kind of want to present to you today, what the landscape looks like in Newark and where things are different than when Camden started. Is it 6 years? Maybe three or four years of the ACO kind of work. Think of how much we've changed since then. There have been so many grants focussed on care coordination. The federal government gives grants to our behavioral health groups. The program has brought care coordinators into the hospitals. And so where Camden ACO is dropping into a community that is already doing care coordination in our individual provider groups, and that really is our challenge which will probably lead us to a different model than what has been implemented in Camden and Trenton. And so we really look at this as sort of a collaborative ACO model where the care coordinators from the hospitals, from Integrity House, from University of Behavioral Health, from our payer partners are all part of the care team because each one of those entities and those individual care coordinators are accountable for each patient. And so we've got to factor all of that in.

And so we see the Healthy Greater Newark ACO



sort of as a facilitator that will provide the communication to all of those folks. And we're really excited about that opportunity because it will be something maybe a little bit different for New Jersey and provide the State perhaps a different experience to evaluate, which I think is in the spirit of the law.

We've looked at some data. The Medicaid claims data was provided to the ACOs in February, and that really helps. Its unbelievable when you start to really look at the data. You know, you know what you know every day, but when you look at the data, sometimes you see those surprises that say, here's a population, you know, this is a population health issue, there's a population that we can't ignore. For Newark, it is clearly the high utilizers. There are significant costs and populations in that rising risk category, you know, before they become high utilizers. And there's also a large number of pediatric high utilizers in Newark.

We were fortunate in Newark to have a grant to start a small pediatric pilot. And it's amazing to see us work on behavioral health issues in our children in our urban areas. And that's something we really want to try and focus on.

The diseases are listed down at the bottom



that we're focusing on. So I'm giving more deeply. Thanks to Mark for giving that allover conceptual. We're sort of down in the weeds in Newark and so we've got to implement this shortly. So we're focused on setting up our model to coordinate care.

This is thanks to my friend, Dr. Jim Walton who works in Dallas, Texas. He created this ACO model several years ago. It's probably one of the simplest descriptions of an ACO I've ever seen, and I can apply it over and over again. His idea is that we want to allow providers to see more. And the way that you see more, see your patients more, see data more, is to implement these five principals. And that's what Newark is following. We're going to coordinate care. We're going to manage the utilization. We've got to use our HIE and selected analytics to do that. We need to optimize that physician culture so they know when and how to work with each other. We've got to report our performance to all of you and to the State. And we've got to really focus on engaging patients and families.

I think that's the exciting part of the health care transformation. Those of us who have been working in this phase for a while, we still haven't gotten quite right this engage the patients and

families. And, you know, this is a place we can't forget and need to focus on.

So the trends that we've kind of seen through our friends at Rutgers Center for State Health Policy and their tremendous work on the reports and looking at data as well. In Newark, in particular, we have the highest rate of readmissions. And, obviously, that's a critical issue for hospitals. We hope to be able to help our hospitals with that. We have the third highest rate for avoidable hospitalization and the fourth highest rate for ED visits. This is the population health in Newark that we've got to focus on.

If we are able to resolve all of the problems or even a little bit, you know, you can see the dollar amounts that are associated with these changes. This is the charge of the ACOs. This is what we're hoping to do, is to be able to improve the quality of care we deliver and reduce some cost savings for the system.

Just to give you a sense of how we're sort of crafting the model in Newark. Again, the data is extremely important. I just brought a couple of slides to give you a sense of how you look at a population. We've got all kinds of views, but I think is remarkable in a way that you can see how large a population that 5



to 14-year-old is in Newark. I think that was one of the surprises that we saw. But, of course, there is children's hospital at Newark Beth Israel, and so we do treat a lot of kids at Newark Beth.

I can tell you from the pediatric ACO experience, asthma and ADHD just comes up consistently. The absenteeism associated with kids from school, the family issues. Every time you went to see a child in Newark, their mother typically was suffering also from mental health illnesses, clinical illnesses. Sometimes she had more than one child.

One family, in spirit of Renee's story, the mother had four children and there was an infestation in the house. All of the kids were suffering. One of the children had a extreme case on the autism spectrum, and so she was home with that child every day. And to try to get her other children out of the house was a challenge for her. And you can imagine a mother dealing with that on a day-to-day basis.

So this is definitely going go be one of our focuses. We are following, again, Camden and Trenton in terms of our high utilizers in Newark. But we're also going to begin to plan for a pediatric focus in Newark.

The next slide gives you an idea what are



the conditions in your populations. Newark is focused on three zip codes. Newark is our largest city in New Jersey. The ACO is focused just those three zip codes that surround St. Michael's, Newark Beth, and University Hospital. And so we took a look at what conditions people are coming in for inpatient stays. And so you can see high utilizers, we think there are about 343 patients that we're going to be deploying that Camden high utilizer model. The median age is just 46 years old. And you can see 46-year-olds already have significant diseases of the heart. Anemia is typically associated with HIV, cancer, sickle cell type problems. And the interesting thing is to see schizophrenia, mood disorders, substance-related disorders.

There is no ignoring that the ACO work is a behavioral health work. There is just no way when you look at the data to ignore that that is our challenge. And I think as Renee so eloquently said, it is not easy work, but this is the work that we're all committed to do.

So just a couple other things that I would add in terms of what's unique about Newark. We are part of the Greater Newark Health Care Coalition that has been fortunate enough, like I said, the pediatric



ACO grant to learn some of the work and begin to integrate all of the -- I would say the vertical solutions that everyone's trying to solve and use the ACO to coalesce those vertical solutions in terms of taking care of the patients.

So we fully expect, for all of my fair friends -- it's good to see you all here today. We really want to partner with each and every one of you. We've had tremendous, exciting conversations with WellCare. We're looking forward to working with you. We also are meeting soon with United. We have met through the Quality Institute sponsored with Aetna. And so we fully want you to be part of our care team and to exchange data amongst each other to help care for your members and our patients who are the same people.

We have as part of our Board, the Urban League of Essex County and Clearview Baptist Church. Those two community representatives are very interested in helping us meet patients where they are, so not in the hospital when they're being discharged, but also when they come to church, when they come to the Urban League for services. We want to be able to have a connection there where people feel safe to talk. You know, sometimes patients will confess things to the

pastors that they don't tell their doctors. The community and where people feel safe is where we expect to leverage our community providers.

I talked about the pediatric focus. That pediatric focus, we hope, will also extend to a family focus. And then one of the other focus areas for the Greater Health Newark Care Coalition is to deploy a grant from the Robert Wood Johnson Foundation on trauma informed care. North Beth Israel is being trained under this grant for providers to understand the effective of trauma on children's health. A child that experiences violence in the home or poverty or drug addiction has a significant percentage of health issues. I think most of you are aware of this work. We're hoping to bring that into our ACO work as well. We have a Clinical Decisions Support Grant from the Department of Health that is actually helping us use our HIE to deliver real time data into the practice offices. We want to be able to deploy alerts when one of our patients gets EED, the same way Trenton and Camden do that today. We want to be able to alert our care team when there's a significant event, so we're going to be using that grant to test that in Newark Beth. We're about two or three months in on that project, and we'll begin to deploy that in July.



And then we also are fortunate. New Jersey Innovation Institute is our technology provider. They've been given that 50 million grant from CMS, the CMMI Innovations Award to get to the practices. So while the ACO is working on the community providers and the hospitals, we're going to leverage NJI out to get out to the practices. They're actually going to be helping transform the care.

So as that all sort of comes together and we work to make sure that we all know that, we hope that we'll implement something really effective on behalf of the patients, for the patients that live and work in Newark and for State Medicaid.

So I want to thank you again. I look forward to working with all of you. So next up is the story from Trenton and my good friend and my good friend Greg Paulson, the Executive Director.

(Applause.)

MR. PAULSON: Thank you, Colleen and Tyla. Thanks to all of you for your time this morning. It's really a pleasure to be here. I wanted to echo the thanks to the Division and to Valerie for all her support.

This has been truly -- I think Colleen's term is great; it's a movement. It's a movement, I



think, that started in Camden with Dr. Brenner. And it's one that's now grown, and I think is in a position to distinguish New Jersey and to distinguish our ability to care for our Medicaid beneficiaries in a new way.

Trenton Health Team started just over 10 years ago. We were started by a catalytic event in the city when one of our two acute care hospitals systems announced plans to close one of their facilities, when Capital Health announced plans to close Mercer Hospital to build Hopewell, actually not far from where we're currently standing.

That need to understand the change in health care delivery and figure out what the impact would be on the community was the event that brought our health care providers together. And today, our Trenton Health Team organizations still is anchored by those four main clinical partners: Capital Health and St. Francis as the acute care hospital systems, Henry J. Health Center as the FQHC that serves the Trenton community, and uniquely the City of Trenton through it's Department of Health.

So we have representations from city government and public health at the table every day. And that, for us, has given us a connection to the



people who can influence some of the other changes, particularly around social determinants that become so critical to impacting quality of care, cost of care, and patient satisfaction.

One thing that's unique about the Medicaid demonstration project -- I'm going to try not to repeat some of the things that my colleagues have previously said. We work so closely together. But this is a local model. There are trends in health care that are. National or that are statewide, but there are nuances to health care delivery, particularly around these challenges that are unique to each community. So the Medicaid Demonstration Project in anchoring the work in a community-based non-profit encourages each community to focus specifically on its needs and challenges and then to use the resources that each community has to address those needs and challenges.

While we learn a lot from Camden and, frankly, from Newark and things that Newark has already done, we need to look locally and we need to listen very carefully to our community stakeholders to figure out what is the right implementation model to work for Trenton.

So I'll talk a little bit about a couple of our initiatives. One of our early work back in

2011-2012 was to address ER high utilization, not on an individual level, but on a system level. And found that our ER utilization in Trenton was 52 percent higher than the national average. That's not surprising, but it's happening because people are going to the ER for things that they should be going to their primary care provider, low acuity, non-emergent utilization.

So we brought in a consultant, Dr. Mark Murray, who worked with our primary care providers on what's called advanced access schedule. It's looking at supply and demand for the provision of primary care. And we found there's a metric called third next available appointment. If you're the third person in line to call for an appointment, what appointment can you get? It was as far out as three months for some of our primary care sources. So there's no way we're going to be able to get people to not to utilize the ER for some of these nonemergent needs if we can't connect them to primary care.

So over a course of about a year and some very hard work, each of the three primary care sites brought down the third next available appointment for their established patient panel to be able to offer same day or next day appointments to their established



patients.

The other piece, there was provider continuity. In an outpatient clinic at one of hour hospital partners, there was essentially no provider continuity. Basically, the deli's list. You came and you took a number. And when your number was called, you got to go in and see a provider. And that hinders the provider's ability to get to know a patient and understand the needs. So we got provider continuity by a panel up to 98 percent in that outpatient clinic environment.

We also operate a health information exchange. It's tightly focused on the Trenton geography. We know patients tend to consume health care in a define market, so our health information exchange is focused on where patients tend to flow. We have just over a quarter million patients in the system, as of today, across all payer types. There's no filter on, just Medicaid or Medicare, which becomes very useful because we know that patients tend to go across payer sources over time.

That Health Information Exchange (HJIE) let's us do three levels of work. The first is to look at the entire population and try to see opportunities for improvement. And that's looking at the real tight



clinical data coming to us from our providers, but also with claims data coming to us now from Medicaid. There resources and challenges available in each those data sets. By putting them together, we have both a comprehensive picture of each patient and a more timely view of each patient so that we can see, for example, who was in the ER yesterday.

That let's us provide the second level of service, which is the surveillance across the population. So we provide a report on every morning to our FQHC which of their patients was seen in the ER yesterday or discharged from the hospital yesterday. So their care managers don't have to go try to dig through records to try to find people. They can immediately know who do I need to reach out to bring them back into care to follow up.

The third level is that individual patient record. And I heard a story yesterday morning from our medical director. He was working with one of his colleagues at a primary care practice, a nurse practitioner. A patient came in with complaints of chest and abdominal pain that normally would have suggested that practice would send the patient to the emergency department for care. The patient said, "Well, I was in the ER yesterday," but the patient was



in the ER at another system. They were in ER at Robert Wood Johnson in Hamilton. The nurse practitioner was able to go into the HIE, immediately review the chart. There was a CAT scan that was done, some laboratory tests. And based on those findings, the nurse practitioner was able to retain care of that patient in the practice based on those test results and not have to send them directly back to the ER for additional care and repeat that cycle. It would have resulted in two Emergency Room (ER) visits in 24 hours.

We also operate a community-based care management team. We've navigated more than 180 Medicaid beneficiaries to date, focusing on those who are high need, are medically complex, are falling through the system largely because of social determinants that make them unable to manage care on their own.

Renee's story was very powerful. We could sit all day and talk about these phenomenally moving stories. I will share one also. We had a gentleman in his early 40s who was referred to us both by our health information exchange surveillance and by a local emergency department. He had been in the emergency department more than 50 times in the previous 12 months. And he was a patient that had been labeled as

difficulty by the ER staff. He was also labeled as noncompliant. He would come in, he was argumentative. And after one inpatient admission, he was admitted to a nursing home for follow-up care. He was actually discharged from the nursing home prematurely because he threw tray of food at the staff, and the nursing home couldn't retain him for safety reasons. He had hepatitis C, HIV positive, he was on renal dialysis, and he weighed 90 pounds, as a 5 foot 6 early-40-year-old.

We did work with him, managed to connect him into care, connected him the program at the Federally Qualified Health Center (FQHC), gave him some of the supports and the social supports and behavioral supports to allow him to stabilize. He came back to us a few months after graduation and asked how he could go back to the ER to apologize to the staff. He weighed 140 pounds. He said very frankly, "I thought I was dying and I was scared and I didn't know what to do with it."

And from a clinical perspective, he's no longer on renal dialysis. He actually managed to come off dialysis.

So the cost savings, not to mention the incredible impact on this man's life, I think, speaks



to what we can do when we take a more holistic view and when we take some time with these really complex challenging patients to wrap our head around what they truly need and meet them where they are and provide those services.

We're very pleased that a week from Monday we're going to be starting our partnership with Amerigroup. It's been a wonderful relationship so far, looking at what we can provide as a community-based ACO and what Amerigroup can provide as a Managed Care Organization and where we can support each other in achieving the aid to the demonstrate project and to each of the Managed Care Organizations overall in providing better care for the beneficiaries.

The other piece I think is unique the ability for these non-profits to seek out and receive investment in community. And while this isn't what achieves a short-term cost savings or outcome change, I think a lot of the utilization patterns, the cost we see, come from longer-term environmental and social challenges that we're dealing with. So we've sought out and received more than $12 million funding over the 10 years of making cultural change, system change, policy change, and environment change to enable the residents of Trenton to better manage their health and



to achieve better health outcomes.

We're very proud to have been selected as a finalist for the Robert Wood Johnson Foundation Cultural Health Prize. In fact, our site visit is next week. And hopefully we're successful and it will be the first New Jersey community to be recognized in that way.

We've had an investment from Trinity Health, a parent of one of our acute care hospitals systems, St. Francis, as part of their Transforming Communities Initiative where they are funding policies, systems, and environment change in the Trenton community to try to improve health outcomes. So these project is a tremendous opportunity statewide for us to look broadly at what's driving the high cost and poor outcomes.

I'll end with one more story. We also are participating with our colleagues at Camden and Newark in the Faith and Prevention Program funded by the Department of Health. It implements a curriculum called Faithful Families Eating Smart Moving More, around healthy eating and healthy activity. And we had a young lady who participated in one of the programs. She was 14 years old and weighted 208 pounds, very quiet, sat in the back. She was the first one there at each program and the last one to leave each night. By



the end of the six-week program, she had lost 15 pounds. And at the three-month follow-up, she had lost 90 pounds.

So her ability now, her confidence had come back out, she was outgoing, she had actually brought some of the principles back into her home. So it transformed her and for her family. And to speak back to health care outcomes and health care costs, a 280-pound 14-year-old is going to have a very different health status over the course of her lifetime than she is now.

So I appreciate all your time. And I thank you.

(Applause.)

DR. SPITALNIK: If the MAAC has questions for any of the speakers, could we go to them first and then open it.

Beverly.

MS. ROBERTS: Hi. First of all, you were all terrific, so thank you very, very much.

This is particularly to Colleen because she emphasized the young agers of the people, but this could pertain to anybody if you're seeing a lot of the younger people.

I was just wondering, Colleen, is one of

your partners Special Child Health Services up in Essex County?

MS. WOODS: I don't recall that. It was Strong Healthy Communities Initiative Grant that provided that initial grant funding, and we're evaluating the data now. And then hopefully we'll vote to be able to bring the program.

MS. ROBERTS: Because that's a free service through the Department of Health. Special Child Health Services is in every county. I'm sure Mary is very familiar with them. And they provide case management for up to 21 years old. They can connect to early intervention services and particularly emphasize autism spectrum disorder or intellectual disability. But there's perhaps a likelihood that there's some undiagnosis among the little ones where if they were diagnosed and if they were connected to Early Intervention quickly, that that could help to minimize the level of disability.

MS. WOODS: I'd love to get a contact name from you if you have one.

MS. ROBERTS: Sure.

DR. SPITALNIK: I would also want to add on that from a surveillance point of view that in terms of health information, the birth defects registry, the



electronic birth certificate, and the autism registry would be very helpful in a predictive way.

MS. WOODS: One of the best things that we heard this year was the IPHD legislation which will begin to put all of the health data and human services data into a data warehouse that Rutgers will manage. So we really look forward to bringing in those kinds of databases and then cross-checking them against school databases and some others. Thank you.

MS. ROBERTS: Sure.

DR. SPITALNIK: Anything else from the MAAC?

MS. HOUSMAN: Sir, in the back.

MR. PYLE: Congratulations on a job well done. It sounds like a very good initiative all around. Kudos to one and all. My question is about additions.

DR. SPITALNIK: Excuse me. I'm sorry. We need your name.

MR. PYLE: My name is Thomas Pyle. I'm a father. So my question is about addictions. It relates to community of interest for me in terms of co-occurring disorders. But I'm also very concerned about the opiate epidemic. And the gentleman from Camden mentioned that the time from intake into contact with a primary care provider is seven days. One of the



challenges I think we're all facing as a state is how long is the time from intake to real treatment for those who have addiction issues, particularly detox and rehabilitation. Could you talk about, first of all, what are those times to treatment? What are the challenges you're facing in getting people the resources they need for such treatment? And most importantly, how are you collecting data which can demonstrate how long is this waiting time so we can help to address it?

MS. MURRAY: That's a great question. And it is something that in Camden that we are -- the resources that we are struggling with. So, for instance, we have numerous patients on our panel who are living with addiction. And when we link them to detox and rehab, which I'm sure a lot of you know, the main issue is that when you go to detox, a rehab bed doesn't open up right when you're done detox. There's always a lag in between.

So to answer your question about time frame, we work with mainly three detox in rehab institutions in the state. And we're always about a two to three-week lag out to get some into detox. And then once they're in detox, they're there for five days, six days, eight days. The unfortunate thing is, we've



never been successful of going from detox to rehab. The patient often comes back into the city, and it's another three weeks, four weeks until a rehab bed opens up. And what we found in that time so often is relapse is so high because they're coming right into the environment that they just left and they just don't have the appropriate resources there. So that is a huge issue.

We currently have two places in the City of Camden where they are prescribing Suboxone and a larger place where they're prescribing methadone. But for a the Suboxone clinics, right now it's a four to five-week wait period. So when we bring a patient in and they get assessed by the addiction doc, it's about a four to five-week time until they can begin to actually having Suboxone prescribed for them.

MR. PYLE: So are you finding anybody then dropping off the screen or are there deaths occurring because we such long waiting times?

MS. MURRAY: I don't know the statistics about that, but I do know that -- I mean, our staff are trained to administer Narcan and we all carry Narcan and our police force carries Narcan. I know there's multiple, multiple overdoses. And I think one of the data from the police force was I think they use Narcan

at least two times on one shift, I believe is what it was. I can't speak to the deaths statistics, but, obviously, it is an issue of the lack of resources for that.

MR. HUMOWIECKI: This is a huge challenge. It's true on the substance use side, it's true on the psychiatric side. People go inpatient, they come out, there are no services, they relapse. A major push when we've had strategic meetings with our Board has been how do we fund more of these services? And so that's the second Suboxone provider, very recent, just the last five months, we're looking to try to expand that throughout primary care within Camden. Same thing on the behavioral health side, and that's part of -- I mentioned the South Jersey Behavioral Health Innovation Collaborative, trying to just expand the amount of resources that are available because it's a five-week waiting list inpatient psych to get into outpatient treatment, and people are relapsing. So all the data around all the cost savings from avoiding readmissions fall by the wayside if you can't connect that service. So a really important comment. Thank you.

MR. PAULSON: And I think you're also hearing from an anecdotal and individual patient experiences or aggregated individual patients, not



truly a measure from the data on the entire community. We do not yet have that measure either. It's a difficult one to find in these data sets.

I can also give you a patient story, a separate issue, a geographic challenge. One of our initial care management clients struggled with addiction to alcohol, among others, needed an inpatient detox bed, frequently ER high utilizer. Got him a bed, but the only available bed we could get him was in Bergen. So very difficult to get him all the way there. And, in fact, all the logistics of timing, we even had the emergency department trying to hold him, but their volume was so high, they had to discharge him. He got discharged at 5:30 in the morning. The ambulance showed up at 5:40 to take him to Bergen. And that missed opportunity was another three months before we could get him back in again. He continued to express an interest in treatment. We just logistically spent a lot time making it happen.

MS. WOODS: To add a ray of hope, I think Seton Hall recently issued the report and study about the licensing obstacles to treat both clinical and behavioral health in one facility. I think the fact that the State is lightening up on those regulations, it has supported some behavioral health homes. We in



Newark, we're going to begin to work with Care Plus and with Bergen Regional to be able to provide to see that. The first thing we need to do is see what's happening and then begin to measure the data. So I do think there is a ray of hope in terms of breaking down those barriers.

MR. HUMOWIECKI: I would say there's also a real interest in the data. The easiest data for us all to get at the beginning was from hospitals. But now we're moving into the space of working with our behavioral health providers and starting to get their clinical data in. They're using our HIEs now. And so there are New Jersey specific laws that make that more challenging. There are federal rules, Part 2 around substance use treatment that made clinical data sharing more difficult. Those are all things that are, hopefully, being overcome through the HIEs and other efforts. So there is hope down the line.

MS. HOUSMAN: Questions? Sir?

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

I'm curious as to whether you have any developmental disabilities providers involved in your local network and coordination in your local network. I ask that because as the population focuses on



developmental disability, it's not universal but they certainly have a tendency for more complex medical issues than the general population. That's one question.

The second question is, are you involving Medicaid consumers and families in the discussion of coordination and how are you doing that?

And I finish what I would have started with. This is a really great effort. I congratulate the Department on looking at this in this way.

MR. HUMOWIECKI: Well, I'll start. In Camden, I think we've had less involvement with developmentally disabled population. It's an area that we would be interested in exploring more but, frankly, they haven't been part of core constituency that founded the organization. So I think that's an area of potential growth over time.

With respect to patients and families, this has been a major initiative that was something we'd always wanted to do but was in part driven by the ACO requirements that you engage the public in your formation and in your development of gain sharing. And so we held a series of public meetings in Camden that we invited folks to. And then coming out of those meetings, we had a list of people that were interested

in getting more involved.

Ev Liebman, who is on our Board, lead a group that formed a Community Advisory Council. The fourth Thursday of every month, a group of 30 Camden residents come together and talk about the strategies of the Coalition of the ACO, talk about hot topics that they're really interested in, pushing us to be more responsive to the community. They go out and they connect the Coalition back to their own churches, schools, local communities. So it's been a really rich sort of bidirectional relationship with our community.

We now have Board seats and Executive Council seats that are filled by members of the community who are elected by this Community Advisory Council. That's happened over the year and a half, two years. And it's been incredibly invigorating for the organization to have the people of Camden, the nonprofessional, the consumer voice right at the table alongside the professional, alongside the CEO. It's made a huge difference.

MS. WOODS: We're obligated as part of the legislation to engage. Medicaid smartly put that into the legislation. I will agree with you that the data that we've looked at in conversations with our payer partners, our DDD members and patients are high



utilizers. There's just no doubt about that. And so I think gathering that data helps us talk to other funders about funding for special project. So we definitely will be looking into that population.

MR. PAULSON: And I would say also I don't think we have sufficient involvement at the leadership level in the development. On the patient engagement, patient story side, I agree, that's been kind of the philosophy that you've grown up around. Our community health needs assessment process in 2012 highlighted for us -- we looked at a lot of data to bring it together to understand community need. But we then held 30 community forums and 300 one-on-one interviews because sitting down and listening to an individual health care consumer Medicaid beneficiary in the community gives you a very different perspective. And we know that we cannot do this work without finding out the individual story, individual need, and involving those individuals in our decisionmaking process.

MR. CASEY: Thank you. If we can be of any help to you in terms with engaging with the DD community, we would be glad to do that.

MR. PAULSON: Thank you.

DR. SPITALNIK: Wayne.

MR. VIVIAN: When you said that you operate



in certain zip codes, right, is it strictly zip codes in Trenton, Camden, and Newark?

MS. WOODS: Yeah.

MR. VIVIAN: Are there any plans for this to expand outside of those -- somebody who lives and operates in Jersey City, Hudson County, we don't really have those issues that people living in the more suburban areas and more of the rural areas, if New Jersey has any rural areas, but of accessing a primary care provider. We have clinics and different things like that. Do you have trouble recruiting primary care providers, like private primary care providers?

I just wonder if are there any plans to expand this to areas where it's more difficult for a consumer to access primary care providers and all those kinds of services. Because the urban areas are a little easier.

MS. DAVEY: So this was legislated, so we have three certified ACOs. These actually qualify to meet that legislative intent. But there's always talk. We have ACO-like models throughout the State. They're not part of this legislation, per se. But absolutely, there are these ACO-likes throughout the New Jersey. And then as we look to see if the pilot is working, sustainable, it's something that we can pursue and



going statewide.

MR. VIVIAN: Because like I said, there are areas that more difficult. This would be more helpful in other areas.

MS. HOUSMAN: We also work with the non-certified ACOs that apply to be certified but were not certified by the State and still help them to try to do this work.

MR. PAULSON: I think your comments are about the primary care providers in these communities is very important. In Trenton, we've gotten to the point where the vast majority, north of 85 percent of the primary care providers are employed by one of the hospitals, the health care systems, the FQHC. That's a different market or landscape to do this work than it is in an environment where there are a lot of primary care providers who are independent. So I think it is important for each community to look at those kinds of characteristics as they're trying to figure out what are the specific interventions they want to employ. And frankly, Trenton's answer to that question is likely not exactly the same as Camden or Newark's because of those kinds of differences.

MR. VIVIAN: Thank you.

MS. HOUSMAN: We're just about out of time

unless there's one more question.

Well, on behalf the Quality Institute, on behalf of the ACOs, we want to MAAC and thank Meghan and Valerie and the rest of the staff at Medicaid, Phyllis who helped bring us here today and set this all up for us. We really appreciate the opportunity.

(Applause.)

DR. SPITALNIK: Thanks to all of you for the work you're doing and bringing it to us and inspiring I us. We look forward to continuing to hear about your progress and to provide support.

We're going to turn to the section of our agenda that focuses on informational updates. And I'd like to call on Liz Shea, the Assistant Commissioner for the Division of Development Disabilities of the Department of Human Services to talk about the Supports Program.

Liz, welcome.

MS. SHEA: Good morning. Thanks for having me. I think this is probably maybe my third or fourth in a row MAAC meeting that I've been at discussing sort of an update on the Supports Program and where we are. So to the degree you're all getting tired of it, I will start with the good news is I actually have new exiting news about the Supports Program today. I want to just



again, like I always try and do, take a quick step back and just explain what the Supports Program is, again, not knowing if some people know or don't know.

So real quick, the Supports Program is the initiative that was included in the comprehensive Medicaid waiver for DDD, which basically will allow us to match and get a federal match on previously a lot of unmatched State dollars to serve people that are living in unlicensed settings. So it will allow us to provide people, primarily living at home, but also living independently on their own in the community and provide enhanced service packages, higher budget amounts, and actually greater deal of services to that population.

That's the Supports Program is intended to do. It took us a little bit of time to begin enrolling people in it for a couple of reasons. The primary one is that it was really being implemented or meant to be implemented in concert with several other changes that and reforms that were happening at the Division.

So one of the things that implement was a single statewide assessment tool, a new assessment tool called New Jersey comprehensive assessment tool that we're now using statewide across the system, but we had to get that in place and get that in use. We develop a single statewide service plan with a single statewide



discovery tool called our person center planning tool, so we had to again get that in place and running. And it's always done with a new care management model, which is support coordination. It's a little bit different from the case management that had been at DDD for a long time.

So we've been working on getting all those pieces in place. They've all been in place for a while now. And we actually last summer enrolled our first cohort, fully enrolled them into the Supports Program.

We kept it pretty small at the beginning. We enrolled about a hundred people or so because it was brand-new program. Our providers were going to be operating in a completely new fee-for-service environment that they had not been operated in. There were new services, new rates they were using. So with so much change -- they are were going to be billing directly into the Medicaid system. So with all that change, we kept it, like I said, small so we could really kind of watch it as issues arose, address them quickly before we grew larger.

So we closely monitored. We had a Supports Program workgroup that met biweekly, mostly on the phone, but biweekly to talk about things that were coming up. Any issues that popped up, we were able to



kind of immediately address them.

To give you just some idea of the kind of glitches we had early on that have since been resolved, we had some claiming issues. Again, there were things that were coded into the Medicaid system from years ago that we didn't realize as we were building our system were there, so there were some limitations. So when our providers actually went to put claims through, some of them were getting bounced back. So again, it was good that we kept it kind of small and contained. All of that got addressed. We had some issues around the authorization process for providers, in terms of them being weekly authorizations and providers having to manage lots of different billing numbers. We've addressed all of those.

So we got it to a point where it became by maybe mid-fall, early-winter really running very, very smoothly. We began enrollment of our second cohort in the Supports Program actually February. We have about 200 or so people now in the second cohort that have been enrolled. And by enrolled, I mean fully enrolled. They've gone through, they have a support coordinator, they actually developed a service plan and they've begun getting services and their providers are claiming through the Medicaid system. But we have another 350

or so people who are somewhere in that cohort, that second cohort, that are somewhere in that enrollment process along what way, so not fully enrolled but they should be relatively soon.

The exciting new news, two things. One is that the Supports Program amendments that we worked so hard on -- and I know I talked about here and many people actually in this room really helped from an advocacy perspective, and certainly from a State perspective on the technical work of kind of getting us there. I know people worked really hard. So the amendments to the Supports Program were approved by CMS on February 11th. And again, just to sort of summarize some of them real quick for those of you who might not be familiar. We changed the eligibility to say you have to at least 21 only. It had previously been that you have to be 21 and have exhausted your educational entitlement. What we were finding is that we had people sort of during the course of that last year who were aging out of the DCF system because they can't hold them after 21 who just were maybe in school but for respite for the other services they needed during that year they needed to access them somewhere. So there had been this gap. So we lightened up on that. CMS agreed.



Very exciting. We added two new Medicaid categories which allowed us to address an issue that we've affectionately termed the non-DACs that we've been dealing with for a couple of years now trying to address, which is, again, a very small group of people, but a group of people who have been previously been unable to get into our system, so we came up with a way to fix that, as well as we aligned the income requirements for people going into our Supports Program with our community care waiver to make that more sort of equal. Previously it had been unequal. So that was approved also by Medicaid.

A big one, again, for a very small group, but a huge, huge concern for that small group, and it was discussed quite a bit here. CMS has allowed us now to make it so that people are able to access private duty nursing from the MLTSS system while they are also enrolled in the Supports Program at the same time. That is taking an enormous amount. The other Medicaid eligibility categories are taking some too, but in particular that one is taking an enormous amount of State collaboration to get us to a place of implementation. We can do it now. The program is known as Supports Program Plus PEN, so we do have an actual way to do it and over time will become even more



automated in the system.

Again, it's a very small group, but for those of you who are not familiar, this is a group of a couple -- right now we have a 120 in the State that we know of, but maybe a couple will age out every year into the system. But someone that will age out of their school system who needs private duty nursing, but other than the fact that they need private duty nursing would be able to very much benefit from the employment and day and other services that DDD has to offer. And previously we've been sort of saying you either have to go completely to MLTSS and you couldn't be in the DDD system, or only come here and then you can't access your PEN, which obviously people need. So there was that was that weird sort of gap in the system. So we're really very happy that we've managed to work that out.

And then there were a couple of technical amendments just removing references to certain states and transportation and some other things that community asked for.

So we're thrilled the amendments were approved. And, again, we're working through a full implementation of them now. But as people present, we are able actual enroll people sort of if need be.



The other kind of major announcement around the Supports Program is that beginning essentially now, starting this month in April, all new presenters, meaning somebody new coming into DDD -- and this is obviously going to big with our graduates this year, the young adults aging out of their educational entitlement -- will be enrolled directly into our Supports Program. So, again, it will be a bigger sort of group coming directly in. This will be the first time we're able to take new presenters directly into that and not have to put them in this sort of interim system that they were then later on flipped into the new program.

There are two sort of exceptions to that, which is individuals who want to access camp this summer. Our Supports Program is not yet able to -- I don't that I should say able. We don't have enough provider adequacy for camp as a service. And some people really want to access that. So for people who want to access camp this summer, we would say don't enroll in the Supports Program until the fall. And for individuals who want to use what's used a self-directed employee, sort of a self-hire, we're still working out some stuff with our facility, so we wouldn't yet be enrolling them in the Supports Program. That doesn't

mean they wouldn't be served. They would get the same services from DDD that people have been able to always get historically. We just won't put them directly in the actual Supports Program yet.

That's pretty much my update. I'll take any questions anybody has about it.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Thank very much, Liz.

With your last point about everyone coming in, the new graduates coming into the Supports Program, how will that impact the non-DACs who are going to be coming who are going graduate?

MS. SHEA: The non-DACs that we know of today, again, that are not new presenters, who are already in our system, as we kind of get the implement down, we're working weekly on how to flip people into the Supports Program. But if there's a new person that's a non-DAC, again, that comes in tomorrow, we'll look at them like anything else. If they otherwise would go into the Supports Program, everything is met, all the other of things in place, then we have workarounds in place that we would be able to enroll them directly right away as they come out of school. We would be able to do that. But won't probably be flipping the group. Again, there's 120 or 125 or so, I



think, of them. We wouldn't be flipping that whole group necessarily wholesale right now. We're working through some implementation stuff. So as soon as we have that a little bit more easily done internally, then we'll flip people as need be.

MS. ROBERTS: Thank you.

MS. SHEA: Sure.

MS. LIBMAN: Congratulations on the enormity of what's going on.

Two things. First, just to clarify what you said about access to camp. So people that graduating this year, they're told they have a choice whether they can enroll in the Supports Program or not?

MS. SHEA: If it's an issue of camp, essentially, yes. That's a really good question, actually.

What we're doing, it has to be done kind of individualized this year as people come out. We're going to look at -- again, if they want camp, we don't have provider adequacy. So if they want camp, they're either choosing camp or they're choosing the Supports Program. You can't have it in the Supports Program.

If they have self-directed employer and they want to utilize one, we're just not going to be able to implement that yet. So we would pretty much be



steering them into sort of our interm system.

If it's not something that we can't do now, though, and there is an adequate provider network, we are expecting people to sort of enroll directly in. So I wouldn't go so far as to say -- you know, it's not like everyone coming out we'll say, "You have a choose, you can be Supports Program or not." The idea is that people will enroll directly in the Supports Program unless they have one of these needs that can't be met there.

MS. LIBMAN: Thank you. And the second question is: What is the turnaround from the time that a provider and my application to Medicaid, what is the turnaround time for that usually.

MS. SHEA: So that's a little bit hard to say in that usually is different or has been along the way. So there was a period of time, I think, early on where we initially did a push trying to get all the DDD providers who had not previously been Medicaid providers enrolled where I think things were taking longer. I mean, they were taking longer both on DDD's side as we were sort of reviewing things because it was new to us, and then also at the Medicaid side. In general, both were taking longer.

The other thing I'll say, things are pretty



quick now. Things don't really sit on either side, as far as I hear. What we do sometimes still see is something that comes in that there's maybe an issue in the application and somehow it's like kind of lost in translation between us, the State -- I would say the whole State -- and the provider what's missing. So there might be a delay in terms of there's back and forth that has to go on to get things corrected in the application, but the actual processing time at this point in time -- I don't know if there's a mandatory time that has to be turned around at Medicaid. But like I said, usually in our office, it's out of our office with two weeks or so. And I think it's usually out of Medicaid pretty quickly after that, two weeks, three weeks, four weeks. We're not talking months by any means. There was a point when I think things were a little bit slower because we had so many people coming in at once.

MS. LIBMAN: So as a provider, you should follow up if you haven't heard from them?

MS. SHEA: Absolutely. Definitely. We have a provider enrollment desk, so you can start there. If you're not getting anywhere, you take it up the chain.

MS. LIBMAN: Thank you.

MS. SHEA: Sure.

MR. CASEY: This is more a comment than question. There are very few states that have made the level of commitment that DDD is making here in terms of picking up all graduates. I know there are a few caveats. That's tremendously important to the system over time. And I think that the Department deserves congratulations on that. It's really an important commitment that will make the system as a whole better over time. I think that has to be noted.

MS. SHEA: Thank you. We love congratulations.

DR. SPITALNIK: Thank you very much. But I'll add our congratulations, and we look forward to either in the June or the fall meeting finding out how things have gone with the new graduates. Thanks so much.

(Applause.)

DR. SPITALNIK: We now turn to an informational update on Behavioral Health Services. And I'm please to welcome again Valerie Mielke, who is Assistant Commissioner for the Division of Mental Health and Addiction Services.

MS. MIELKE: Good morning. Thank you very much for having me here today. It's really to talk about our rates. It's a really significant initiative



that we're undergoing here in our Division.

As many of you know, Governor Christie actually announced $127.5 million coming into our Mental Health and Addiction Services System. And that's in the proposed budget for State Fiscal Year 2017. Out of that, 107.5 million of those dollars are federal financial participation of Medicaid. So Medicaid federal dollars are coming into the State. And to enable that to occur, there's $20 million increase in State investments that are proposed for the budget.

So our initiative is heavily reliant on our providers becoming Medicaid providers, which is something that we have acquired as a part of our contracting. But in addition to that, that our providers are working and doing their due diligence to enroll individuals, to support individuals to enroll in Medicaid where appropriate.

We actually looked at and built up from the ground up 95 behavioral health rates for adults who have substance treatment for individuals who have substance use disorder and/or a mental illness.

Following Governor Christie's budget address, we kicked off a series of meetings with our mental health and substance use treatment providers to



share with them the rates, to share with them the underlying principles and development of the rates, and to lay out what they can expect going forward.

Since February, we've had well over 25 hours that we have spent in meetings with our stakeholder to process the rates and the transitions.

One of the good news pieces that's in our rates is the true up, what we refer to as the true up. What that means is that when the decision was made for New Jersey to expand Medicaid eligibility, that individuals who have a substance use disorder who were originally in Plan A, they continued to have availability to services through Medicaid reimbursement for detox services. But for individuals who became eligible for Medicaid through the true up, there were a Host of other services that were available to them that included outpatient services, intensive outpatient services, short-term residential services, detox services, and those services through Medicaid reimbursement were not available to individuals who were in Plan A.

Come July 2016, with the true up, those individuals who are in Plan A are going to be eligible for the same Medicaid services for reimbursement for individuals who are part of the expansion program. The



rates will be the same and the services that are available will be the same, as well.

In terms of our implementation timeline, looking at July 2016, that proposed rate changes for Medicaid will be implemented, that in July 2016 that our substance use treatment services that are transitioning from our contract-based services into fee-for-service, that that change will be affected July 2016. And then in January 2017, mental health services that are currently in state deficit funded cost based contracts, those State dollars will transition to fee-to-service from January 2017.

Not all of our services are transitioning to fee-for-service in this first phase. So there will be some services that will be transitioning in a second phase. We anticipate that being July 2017, but certainly there will more information to come on that.

The feedback on the rates and the proposed rates overall have been fairly positive. There have been concerns that have been raised, concerns regarding some of our outpatient rates in particular, specifically as it relates to supporting the salaries of psychiatrists. We have received some feedback related to our community support services rates. And we received feedback as it relates to our programs for

assertive community treatment rates, particularly as it relates to the State rate that we struck.

What we are hearing and what we found in looking at information from our providers is that Medicaid eligibility for individuals who enrolled in our packed programs that those ratios are significantly lower than what we see in our broader services. And so we actually just recently issued a correspondence to our providers to equalize the State rate to the Medicaid rate. And that correspondence was issued a couple of days ago.

Based on the feedback that's coming in from our providers, we're continuing to do our due diligence, continuing to collect some data and information from providers who are submitting that to us, evaluating that information, and looking at the rates. So I would anticipate that you will continue to hear information and feedback from us as this process continues to unfold, which leads to me communications.

We current have on our website the PowerPoint presentation that we presented to our providers in February and March related to the rates. We've been updating that PowerPoint as we have been changing information and as that becomes available. In addition to that, we also have on our website a link to



You Tube videos for the presentations that were presented to our substance use treatment providers and our mental health service providers on the rates so that in addition to the PowerPoint, we actually have a contact with information in the PowerPoint in video form as well.

We also have recently uploaded frequently asked questions on our website. We'll continuing to modify and update that as questions come in, as we respond to them. That is already up on website.

And upcoming in May and June, we're going to have what we call listening sessions with our providers to provide yet another additional forums for providers to talk to us about the transition, what their experience is as they're transitioning to fee-for-service, what some of the challenges are, so that we can continue to be responsive. Those listening sessions will be regionally based. There will be a correspondence that will come out at end of this week, early next week. So we'll have a forum in the southern region of the State, the central region of the State, and the northern region of the State.

We have begun to roll out prior authorization training. So for our substance use treatment services, prior authorization will soon be



required in order for our providers to bill Medicaid, as well as bill the for State dollars for services that they would like to provide. And so those training sessions have already commenced.

We are also going to be convening a Mental Health Provider Advisory Group. And that group will work with us as we begin to -- we are currently building a mental health application to collect client specific encounters on the State side in terms of reimbursement. And so we will be working with a small group of providers to help to not just develop that interface, but also to provide us with feedback as they test that interface to identify if there are any issues, challenges related to that so that we can make sure that interface is ready for rollout come January when the mental health services State dollars go fee-for-service.

One other thing that we are doing -- this is in partnership with Medicaid -- is presumptive eligibility training. So we issued a survey out to our providers to assess interest in participating in training and certifying staff within their organizations to be able to process and identify individuals as being presumptively eligible for Medicaid. The advantage to the provider is that as



individuals are referred and coming into their system, the presumptive eligibility process is about 72 hours or so from the submission of the application to actually approval, which will mean then in terms of cash flow for providers, providers will be able to then begin to bill Medicaid at that point in time. And then it's the provider's responsibility to collect additional information and data that's needed to then complete the Medicaid eligibility process.

To date, we've heard that there are about 700 individuals across the State who are interested in becoming certified to be able to determine presumptive eligibility. So we will be following up with those agencies and individuals and scheduling those trainings for individuals to be certified to do presumptive eligibility.

So that's sort of a high level overview in terms of our rates and our rate rollout.

Are there any questions or anything?

DR. SPITALNIK: Thank you so much.

Questions from the MAAC.

Beverly.

MS. ROBERTS: Thank you, Valerie.

MS. MIELKE: You're welcome.

MS. ROBERTS: So this is a concern that I

have and I think other people in the developmental disability community have as well. So going back, and I know you've only with the Division a relative short time, several years ago there was a dual diagnosis task force appointed by then Commissioner Jen Velez. And that met for quite a period of time. It was dual diagnosis for people with an intellectual disability and a behavioral health disorder. It met for quite a time and had a great report that was completed and presented to the Commissioner. And nothing really happened with that. And then later there was going to be the ASO and BHO that was happening. And the decision was that even the people with intellectual disabilities who currently, if they have a dual diagnosis, their behavioral health is from the Medicaid HMO, it's not in the fee-for-service world. And that's the way it's been for a number of years. But the plan had been to have those people leave the Medicaid HMO and be part of the new ASO or BHO that was discussed for quite a period of time. And there was a separate workgroup from that was looking at dual diagnosis and made very good recommendations. And now that's not happening.

So I guess my question is with everything that's moving forward and the tremendous amount of



planning that's going into the non-DD population -- and I think Liz may not be here now. I was hoping to have both of you here at the same time to address this. And I know you can't give me an answer at the moment, but I wanted to bring up that this is an area of very significant concern and to find out what we can really do to move this forward for this particular population.

MS. MIELKE: I'm happy to come back prepared even to talk about some of the initiatives that in partnership that we have had with DDD to serve individuals who are duly diagnosed. So since the issuance of that report, there have been things that we have worked through with DDD in terms of moving some initiatives forward. So I think maybe when you determine as appropriate, we can come back and we can really present and talk about what we've done as next steps. That would be helpful.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Other questions?

Wayne.

MR. VIVIAN: Any updates on when the regs are coming out, the CSS regs?

MS. MIELKE: The million dollar question. The Community Supports Services is a new service that will be available in New Jersey. We're rolling it out



initially for individuals who are in support of housing. So the draft regs were posted on our website. We received comments and questions. We've actually completed our response for the questions and comments that were made. And now the vetting process for that has begun. So the regulations, I anticipate, will be promulgated within the next couple of months. But we just we need to go through that vetting process.

So as it relates Community Support Services, and our providers along with our Division along with Medicaid, we've done a lot of prep work in preparation for the implementation or Community Support Services. We're continuing with those efforts so that once the regulations are promulgated, our providers are ready to begin to provide that service.

MR. VIVIAN: We can't do CSS until the regs are approved, though, right? We can't start to bill Medicaid without the reg?

MS. MIELKE: Yes, that's correct. You cannot bill Medicaid without the regulations being promulgated. You actually need to be licensed as a CSS provider. So we have developed, along with our office of licensing, an attestation form so that agencies don't have to wait licensing to come out to do licensing reviews, but they will complete this



attestation form, submit it to Office of licensing. And our Division along with Office of Licensing will review those documents and then agencies will be able to be licensed as Community Support Service providers. And then once they're licensed, they will actually need to submit an application to Medicaid for the special program code to be able to specifically bill Community Support Services. So once of the regulations are promulgated, I imagine that it will be at least six weeks to two months before actual billing occurs.

MR. VIVIAN: Okay. Thank you.

MS. MIELKE: You're welcome.

DR. SPITALNIK: Colleen.

MS. WOODS: Now, would you consider the ACOs a provider? Can we potentially be a provider for the Presumptive Eligibility process?

MS. MIELKE: I'll have to differ that to Medicaid.

MS. SMITH: Right now all the medical providers can be --

(Multiple speakers.)

DR. SPITALNIK: I'm sorry. It's too small a conversation, so it needs to be louder, please.

Did people hear the question about the ACO?

The question was could the ACO be considered

a provider for Presumptive Eligibility.
And the answer was?
MS. SMITH: The providers within the ACO can.
DR. SPITALNIK: Josh Spielberg.
MR. SPIELBERG: Josh Spielberg from Legal Services of New Jersey.
It sounds like you're doing a lot of great work in terms of communicating with providers and interacting with providers. And I heard you say that there was going to be a provider advisor. I wonder do you have set up now or do you have plans to set up a broader advisory group that includes consumers and family members of consumers and advocacy groups?
MS. MIELKE: We have a communications group that was a part of our strategic planning process that is comprised of families and consumers, as well as providers. We are taking individuals from that group to participate with us as it relates to the communications going forward for families and for providers. We actually utilize that core group to help to develop some communications that our providers are using, so basically Community Support Services that Wayne spoke of for communications to go out to consumers and to providers regarding that. And we're



going to do the same thing as it relates more broadly to the rollout of the rates.
In addition to that, I spoke about the listening sessions. There will be a listening session for consumers and families, as well, to gather additional information in from consumers. So we do have a structure built in. It is important for us to make sure that the correct information is getting out to consumers and to family members and that they have a direct link back to us in terms of what they're hearing. So we're building that into the process, as well.
MS. ABRAMS: Hi. Mary Abrams, New Jersey Association of Mental Health and Addiction Agencies.
A two part question on CSS. When the rates first came out at those meetings and were distributed, I think it was said that there were a couple errors on there. I was wondering if it's on the website. Or if not, how would I get it updated if things are going to be added?
And the second part is we recently just heard that there will be a communique coming from your office over the Department regarding the CSS rates, and we're wondering when we might be.
DR. SPITALNIK: I'm so sorry, but can you



repeat the last part, please?
MS. ABRAMS: The second part was when we might expect communique from the Department or from the Division that they said will be forthcoming about their review of the Community Support Services rates?
MS. MIELKE: So in terms of the Community Support Services rates in the PowerPoint, there were some errors in the rates that were in the PowerPoint and then there have been also some questions and concerns about some of the rates that were in the PowerPoint. So we've been really working on those rates and then are going to publish the PowerPoint once we nail some of those other rates down, just so that what goes up on the website reflects how we're moving forward.
In terms of the communication regarding Community Support Services, I anticipate that that will be out within a week.
MS. WENTZ: Debra Wentz.
So we understand that there's another communique also that will address some other questions and concerns about rates, including the outpatient rates which you mentioned. So is that communique also coming within the next week?
MS. MIELKE: So this is an evolving process.



We didn't want to wait until we had all of our analysis completed to roll out rates. So it's evolving. Deb's question as it relates to the outpatient services and those rates, we're continuing to take a look at that. I don't have date certain as to when that will come out. We're still looking at that internally and doing our due diligence.
DR. SPITALNIK: One more question and then we'll move on.
Dan.
MR. KEATING: Dan Keating, ABCD.
I just wanted to reiterate something that Beth said relative to dual diagnosis, mental health. The Mental Health Task Force is now in the process of, again, updating some of their information. I think it would be a great time to initiate some of that dialog again with the Division and figure out where we want to go with that. So I just wanted to point that out.
MS. MIELKE: The Mental Health Task Force.
MR. KEATING: Yeah, the Dual Diagnosis Task Force that created the report several years ago. One of their products was a crisis handbook for families. And they're in the process of updating that and getting information from a number of stakeholders, so I think it would be a good juncture to maybe revisit.

MS. MIELKE: Thank you.
DR. SPITALNIK: Thank you so much, Valerie. I appreciate it. And we will figure out what the best timing is around engaging the issue of people with dual diagnoses of intellectual disability and mental health.
MS. MIELKE: Thank you very much.
DR. SPITALNIK: Thank you so much.
We have three more informational updates, and we're going to start with Stu Dubin on Managed Long Term Services and Supports and then go to Carol Grant about Appeals and Grievances.
I'd ask both of these presenters to somewhat abbreviate the information because I want to make sure that we also get to the full update about FamilyCare.
So, Stu, welcome in this role.
MR. DUBIN: Thank you. I'll be the first say the first to say good afternoon to everybody.
I think last meeting we showed about 18 slides of MLTSS data information. We truncated that this meeting to about six. I'll run through them real brief and quick. And if we need to build on those for future meetings we can.
(Presentation by Mr. Dubin.)
(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: That was great. You really extracted information for us to be able to think comparatively and see all the progress in the program.
Thank you.
Are there questions on MLTSS?
MR. VIVIAN: Generally, do you have any data about how long it takes from the time you initiate contact for MLTSS assessment to how long it actually -- when it actually takes place?
MR. DUBIN: I think that's a Nancy question.
DR. SPITALNIK: Nancy Day.
MS. DAY: I'm Nancy Day. I'm the Director for the Division on Aging Services.
In terms of the assessment process, how long is it taking for that assessment process, we did initially have problems with the time frames because there was a huge learning curve, both on our MCOs as well as review and the Division has to go back if anyone is denied as to looking that they would not be eligible. So we had to go back out and do that. We're really starting to catch up on it. And in the southern region, we're really being able to turn around those assessments real time. We do still have some delays in



the northern region, and we're trying to address that by reallocating some of the assessments for a particular MCO to the southern region so that we can address it. So we are trying to be and I think we are much more timely.
If there are problems we have always said to, whether they're providers or individuals, to please reach out to our northern or southern regional office and they will deal with that person with a one-to-one basis.
MR. VIVIAN: Okay. Because to go back to the managed care company, to the case management department, is not really proving to be helpful.
Is there a number for the northern department?
MS. DAY: There is. I don't have it with me. But I will make sure that we can send it and then everyone will have access to those numbers.
MR. VIVIAN: Okay. So it's better than go directly to managed care company again?
MS. DAY: Well, again, there's two different processes. And I think that that's what we have to try to help resolve. And then through our quality assurance, our MLTSS quality assurance, they also deal directly with issues, which is Maribeth Robenolt. So



if there's particular problem with an MCO as opposed a problem with the State, then we can deal with it together. We work very well together.
MR. VIVIAN: Well, we initiated a call for an assessment for of consumers in the supportive housing program, and it's been a while. It's been longer than what they told us.
MS. ROBENOLT: I can give you our number. Our number is 609-584-4304.
MR. VIVIAN: Okay, thank you.
MS. ROBENOLT: And if you want to put it to my attention, just leave a message for me.
MR. VIVIAN. Your name again.
MS. ROBENOLT: It's Maribeth.
DR. SPITALNIK: Thank you.
Any other questions from the MAAC?
Gwen.
MS. ORLOWSKI: Hi. Gwen Orlowski from Central Jersey Legal Services. Thank you for that data and thank you for condensing it. A couple quick questions that struck me looking at it.
With the increased number of people from about 42,000 to about 46,000 over the last almost a year and a half or so with the data, so that 4,000 participant difference, do you have a sense of whether

those are new to system or people who were in managed care, the managed care had recognition that they really might be MLTSS because they were getting PCA, by way of example, and so that there are people who transitioned from one kind of Medicaid to MLTSS?

MR. DUBIN: It's the transition. It's folks working their way through the managed care from being just Medicaid person to an ADD and then into MLTSS. And needs are assessed as ar needed to move folks from ADD into MLTSS.

MS. ORLOWSKI: So it's both, new people to system and people who --

MR. DUBIN: Yes.

MS. ORLOWSKI: Because one of the things that was discussed leading up to this was whether or not there would be so-called woodwork effect. And so I'm just curious, what does 4,000 people mean? Does that mean there was no woodwork, there was woodwork? How do think about that number?

MS. GRANT: We don't believe that it's woodwork. Remember that the MCO can recommend someone for assessment, but it really is the State that has to determine the level of care. So if in fact somebody does not rise to the level of meeting this level of care, then they're not eligible. We really refer to it



as growth. When you have a natural aging process, you know, people's needs do change as they grow older. And it is something that we monitor.

DR. SPITALNIK: Ev Liebman.

MS. LIEBMAN: Ev Liebman, AARP. Thank you for the presentation and the info.

I'm not sure if this is the right place to ask, but I'm just wondering if you can give us an update on where we are with the concept paper.

MS. DAVEY: I'll update that.

MR. DUBIN: That's coming. Stay tuned.

DR. SPITALNIK: Anyone else?

Thanks so much, Stu.

And we'll turn to Carol Grant about complaints, grievances, and appeals.

MS. GRANT: Generally speaking, we usually have a tag team. We have Maribeth and I go up and present two sides of the complaints, grievance, appeals information. I know people had ask for a full year's worth of data at this meeting. Unfortunately, we're still not quite there yet on acute side, but we do have three quarters of data related to this. And I'm going to go through it. And as we get this information, we'll update the MAAC through the normal process.

(Presentation by Ms. Grant and Ms. Robenolt.)



(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.

Josh.

MR. SPIELBERG: So in appeals there are four possible levels. The first two are within the HMO, then there is an outside review organization, then there's and fair hearing. You don't have them broken down there. That would be very important to break down because it's not surprising that within the HMO there would be a lot of denials. That's a usual practice. But once you get into the other areas, they're usually more -- so it would be very helpful to break it down by appeal category.

MS. ROBENOLT: Right now the way the report is structured and the way the contract requirement is is that -- this is MCO reported data, and it's all appeals. This is the self-reported appeals here.

MR. SPIELBERG: So those are only the internal MCO appeals that you're reporting?

MS. GRANT: It wouldn't include fair hearings. Not every service gets an IURO. PCA, for



example, does not.

DR. SPITALNIK: What's the acronym?

MS. GRANT: Independent Utilization Review Organization. It's the Department of Banking and Insurance independent review.

MR. SPIELBERG: Now, do you keep track of those appeals, too, or not?

MS. GRANT: Appeals are reported. The IURO is reported to the health plans, not to the State. And fair hearings is something that's monitored through our office of legal and regulatory affairs.

Your concerns are duly noted and we really try to look at how do we do the best reporting around these. We don't disagree. If we can figure out a way to do it, it would be useful information for you. So we're really trying figure that out.

MS. ROBENOLT: We're still researching was to do that systemically. A lot of it is an extremely manual process because multiple things are crossed. And again, because these are incidents of appeals, it's not necessarily a member specific number. But we're still looking to try pull that specific data.

DR. SPITALNIK: Gwen.

MS. ORLOWSKI: Gwen Orlowski, Central Jersey Legal Services.

I want to echo some of what Josh said. It sold like you get it. We need more transparency. We really need to know what's being asked, what's being delivered. Are there then matrix that you're looking at?

One thing I want to note is I feel a lot of pressure -- a lot of pressure comes to bear when I'm representing clients and we can resolve a matter to withdraw the fair hearing request. I feel very uncomfortable about that for lots of different reasons. But one is I'm concerned about whether or not it's being reported. And I think I raise this at the last meeting.

MS. GRANT: You did.

MS. ORLOWSKI: So just thinking forward as you're collecting information, I would think that it should stem to when it's filed, not whether or not it's actually seen through fruition. Because a lot of these do resolve informally and we just withdraw -- you know a common practice is to withdraw the appeal and/or the fair hearing.

I also just wanted to briefly note that there's rumblings coming from our national partners that the managed care regs are going to come out any day now. It might not change it, but it might change



significantly the appeal process. And so there are several of us in the advocacy community who would really like to be able to input in that. And I know we talked to some of the MCOs and they feel similar. We can have a good product on the other side. So continue to stand ready when that happens.

MS. GRANT: Absolutely.

DR. SPITALNIK: One more, and then I want to make sure we get to the FamilyCare update.

Kevin.

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

I want to raise again the issue I raised last month, and that is how are we communicating to consumers and families that they have a right to appeal or file a grievance. I'm going to extend a little bit from what I said last month. It is my belief through a series of conversations I've had with folks that at least in the DD system -- and I'm looking at the comprehensive issues of appeals here -- that at least in the DD system families are generally unaware that they have a right to file a grievance or file an appeal. I have had some further conversations which is indicating to me that may be a problem across the Medicaid system. I think it's something we need to



look at very closely. So what I'm going to suggest to the MAAC is that the MAAC take on a thorough examination of that issue over a period of time. Are we informing in an understandable comprehensible way families and consumers at the time of an adverse finding that they have a right to appeal that finding and what the process for that right is and where there is help to file that. I think this is critically important, and I would urge the MAAC to take that on as issue. I would love, by the way, I would absolutely love to be wrong about this. I would love to be proved wrong on this topic. And if a study of it finds me wrong, I'll be one of the happiest guys on the planet.

DR. SPITALNIK: Your concerns are noted. We need to figure out what the methodology is because we don't take on studies, per se, that the MAAC conducts. But whether we can shake the request for information, I do think there is the issue that people are aware that their funding has changed but not necessarily aware of what their rights are being in a Medicaid program.

MS. GRANT: I had one comment really that I'd like to make. It is a requirement that people get informed. And actually, Medicaid and the Bog Center worked very close to create a handbook for individuals with developmental disabilities about how to make



managed care work for them. And there is information in there about appeals. And it's my understanding -- I mean, we're willing to work with anyone to make sue we're improving that process.

I don't know. And I would like to be able to say you are wrong and people are being informed. Plans must inform, they must assist people to walk through the process.

If you have specific instances where that's not happening, we need to know it. We absolutely need to know it. It's a requirement. And then perhaps we can talk internally and make some recommendation for how we might get at this in a better way.

DR. SPITALNIK: But I think part of the issue is that what's been done previously was around acute care. I think people don't have an understanding of necessarily where their position versus long-term services. So we will take that and try to shape the issue.

Thank you.

And I apologize. We have a very full agenda where we're getting a wonderful set of information. And I'm delighted that we're turning to Meghan Davey to give us an update on FamilyCare.

MS. DAVEY: So usually this is standing

agenda item. Valerie usually gets to do it. Now it's my turn. So it's just a FamilyCare update on enrollment. The MAAC asked us to give you updates on some topics that they've asked for.

(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: I wanted to raise a question about the 1115 renewal package. Will there be a synopsis or a summary that indicates the changes and the new initiatives that will help people wade through it?

MS. DAVEY: Yeah, we can to like an executive summary.

DR. SPITALNIK: Thank you.

Other questions?

Beverly.

MS. ROBERTS: So when do you expect that this is going to be available?

MS. DAVEY: I would say by mid-May. Right now it's a lot of information they're requiring for this renewal, just from what we've done over the last four years. So that's in the final stages and then it



will go through the Department for sign-off and then it will get posted.

MS. ROBERTS: So will it be sent to the MAAC?

MS. DAVEY: Phyllis has a Listserv. We said once it's posted, we will send to our Listserv, which includes the MAAC, that it had been posted.

DR. SPITALNIK: One more question. The evaluation that's being done of the Comprehensive Waiver by the Center on State Health Policy, what's the timing of those results?

MS. DAVEY: They require a draft of the interim evaluation as part of the renewal package so that would be included. And then they have during that course of the year to finalize the actual evaluation.

DR. SPITALNIK: So at the end of the meeting as we build our agenda for our next meeting, in addition to review of the new package, would it be timely to also have the interim evaluation -- that might have to be vetted with people doing it, but that might be helpful.

MS. DAVEY: Yeah, we can talk to Rutgers about potentially presenting their draft findings.

DR. SPITALNIK: Okay. Thank you.

Other questions?



MS. EDELSTEIN: Just a quick question Meghan. I'm just looking at the time frame. The MAAC meeting is June 15th, which is two weeks before you have to submit the package.

MS. DAVEY: Yes. It's going crunch time. But the comments, you'll have it by mid-May. So hopefully come prepared with your comments so that we can vet them. And honestly, once we'll have it, we have to summarize all the comments for CMS. But during that year is a year of negotiating and working through. So it's not like that's carved in stone on June 1st.

MS. EDELSTEIN: You're going to have a lot of reading to do that period of time.

MS. DAVEY: A lot of reading.

DR. SPITALNIK: And in the first Comprehensive Waiver, the MAAC served as one of the major forums for stakeholder input. I don't think that as a committee we actually had unified comments, but rather provided the forum. And that would be a decision to be made going forward.

Others?

Josh and then Paul.

MS. SPIELBERG: One comment and then one question.

As you were going over the numbers, Meghan,



we see that over 400,000 people have been added since Medicaid expansion. And I think all of us should take pride in that. I think the MAAC was instrumental in convincing the powers-that-be to adopt the Medicaid expansion. And I know Valerie and Meghan have been instrumental in implementing it. And I think it's important not to take that for granted. These are people who otherwise wouldn't have had coverage and now have coverage.

MS. DAVEY: Thank you.

MR. SPIELBERG: And now the question. You said I think there were 60,000 new enrollments in March and you also said that 12 percent of the people who had gone on the FFM came back on. When you list new enrollments, does it include people who were on before but came back on?

MS. DAVEY: Yes.

MR. SPIELBERG: Do you have it broken down?

MS. DAVEY: In that number they would included as a new enrollment.

MR. SPIELBERG: That would be helpful to know to get those statistics, how many are new enrollments, brand-new and how many were off for three months six months a year.

DR. SPITALNIK: Paul.

MR. BLAUSTEIN: Paul Blaustein, NJCDD.
I'm just wondering. The renewal of the Comprehensive Waiver, would that be complicated at all by the inability to renew the Community Care Waiver?
MS. DAVEY: No. Totally separate.
MR. BLAUSTEIN: There's no indication of any connection between the two?
MS. DAVEY: Unless we want to put the Community Care Waiver into 115, which is a discussion.
DR. SPITALNIK: Gwen.
MS. ORLOWSKI: Gwen Orlowski, Central Jersey Legal Services.
I want clarity. No concept paper?
MS. DAVEY: So the concepts will be included in the full renewal packet.
MS. ORLOWSKI: Should we expect it to be the narrative form that the original application was, I think, in September of 2011? Or will we expect it to look more like special terms and condition?
MS. DAVEY: It's a combo of both.
MS. ORLOWSKI: All right. Thanks.
DR. SPITALNIK: One more question.
MS. ROBAYO: Linda from Sunovion Pharmaceuticals.
Can you go back to the Margaret Rose



information?
MS. DAVEY: Sure. And that will all be posted.
DR. SPITALNIK: Thank you so much.
So far for our agenda, we have the 115 Waiver and potentially the evaluation report. And I think we should devote significant time on the agenda to that; the issues have been raised about DDMI; an update on the Supports Program which seems it would be logical in October when there's been more enrollment, if this is's acceptable to Members; and an update on credentialing; and the typical on every meeting update on FamilyCare.
Are there any other agenda items from the Members?
Do I have a motion for adjournment?
MS. ROBERTS: Motion to adjourn.
MR. WHITMAN: Second.
DR. SPITALNIK: Roberts. Second, Whitman.
And it's 12:59. Have a good spring. Thank you all for your participation.
(Meeting adjourned 12:59 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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