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 thelscribe@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/

1

#### **ATTENDEES:**

Tom Pyle Evelyn Liebman Linda Robayo Christopher Bruette Cheryl Reid Dan Keating Willianm Healy Alison Dorsey Brian Atkisson Matthew Minella Colleen McLaughlin Tom Grady Kitty Lathrop Renee Murray Natassia Rozario Shabnam Salih Mark Humowiecki Jennifer Farnham Mary-Catherine Bohan Kimberly Devinney Kimberly Salomon Lisa Eisenbud Chrissy Buteas Karen Brodsky Lillie Evans Heather Watson Joshua Spielberg Carol Katz Gwen Orlowski Christine Fares Walley LIFE St. Francis Melinda Martinson

Jennifer Dingler

Cynthia Spadola

Parent AARP Sunovim Pharmaceutical Aetna Better Health New Jersey Aetna Better Health New Jersey Alliance for the Betterment of Citizens with Disabilities Alman Group, LLC Amerigroup Association of New Jersey Chiropractors Association of New Jersey Chiropractors Boggs Center Rutgers University Brian Injury Alliance Burlington County Board of Social Services Camden Coalition of Healthcare Providers Center for State Health Policy Community Care Behavioral Health Organization Community Care Behavioral Health Organization Community Health Law Project Get Going, LLC Homecare Hospice Association of New Jersey Health Management Associates Horizon NJ Health Horizon NJ Health Legal Services of New Jersey Katz Government Affairs Legal Services of Central New Jersey Medical Society of New Jersey Mental Health Association of New Jersey Monmouth County Board of Social

Services

#### ATTENDEES:

Stacy O'Conner Monmouth County Board of Social Services NJ Association of Mental Health Mary Abrams and Addiction Agencies Debra Wertz NJ Association of Mental Health and Addiction Agencies NJ Council for Developmental Kevin Casey 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. Optum, Inc. Karen Shablin Princeton Public Affairs Group, Inc. Sonia Delgado Mary Kay Roberts Riker, Danzig, Scherer, Hyland & Perretti, LLP Robert Wood Johnson Barnabus Health Joseph Jaeger Alexander Puma Robert Wood Johnson Barnabus Health Kathleen Lockbaum Salem County Board of Social Services Steven McRae Sequenom Labs Linda Robayo Sunovion Pharmaceuticals Trenton Health Team Gregory Paulson 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 Xerox Government Health David Weber Nicole McKnight Centers for Medicare & Medicaid Services Michael Simone Centers for Medicare & Medicaid Services Maria Varon Centers for Medicare & Medicaid Services NJ Department of Human Services Dawn Apgar Frieda Phillips NJ Department of Treasury NJ Department of Human Services Brian Francz Noah Glyn NJ Department of Treasury

### ATTENDEES:

Carol Grant Assistance Thomas Lind Assistance Valerie Mietke Assistance Pam Orton Assistance Mariam Rashid Assistance Assistance Heidi Smith Assistance Assistance Development Services Robin Ford Services

Jodie Flandinette NJ Division of Medical Assistance and Health Services NJ Division of Medical and Health Services Maribeth Robenolt NJ Division of Medical and Health Services NJ Division of Medical and Health Services Phyllis Melendez NJ Division of Medical and Health Services Terrie Whitfield NJ Division of Family Joshua LichtblauNJ Medicaid Fraud DivisionDavid DrescherNJ Office of Legislative NJ Office of Legislative

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	5		7
1	DR. SPITALNIK: Good morning. I'm Deborah	1	of the minutes, an informational update, and a series
2	Spitalnik, and I'm delighted to welcome all of you to	2	of presentations.
3	the April 20th meeting of the Medical Assistance	3	We've been fortunate in our interaction as a
4	Advisory Council (MAAC).	4 5	Council and as the larger community that we have not
5	In accord with the New Jersey Open Public Meetings Act, adequate notice of the schedule of this	6	confined ourselves to specific limited periods of time when the public can provide input. We've been able to
7	meeting and the public notice and invitation to attend	7	have a dialog around the issue at-hand that we're
8	was transmitted to the Office of the Secretary of State	8	dealing with. But if at any time that started to
9	and advertised appropriately.	9	become unwieldy or unfeasible time-wise, we might have
10	I'm also obligated to let you know, as	10	to institute that kind of limitation. I hope we don't.
11	guests in the State Police Headquarters, that I need to	11	I think we've all been enriched by dialog.
12	let you know about an emergency evacuation procedure,	12	So members of the MAAC will introduce
13	which I have no doubt we will not need. But upon	13	themselves. From a public health perspective, it's
14	hearing the fire alarm or evacuation announcement, I	14	probably better that we not pass the microphone around,
15	need to ask you to quickly leave the building via the	15	although I'm sure it's all allergies for everyone, as
16	nearest exit and go to Lamppost No. 9 in the large	16	it is for me. When you introduce yourself, please do
17	parking lot. And once there, you will report to	17	it clearly so Lisa Bradley, who takes our wonderful
18	Meghan Davey and Phyllis Melendez who will check your	18	notes, can hear you. When you ask a question during
19	name off of the attendance list and wait in the	19	the conversational part of the meeting, please identify
20	designated area.	20	yourself if you're not a member so that it can be
21	Now that I have done the official business,	21	included in the record.
22	my first piece of business today, before I introduce	22	So with that, I'll ask Dr. Whitman to start.
23	the MAAC and ask all of you to introduce yourself, is	23	We'll go this way and then we'll go to the public.
24	to extend to Meghan Davey, the new Division Director	24	(Members of the MAAC introduce themselves.)
25	for the Division of Medical Assistance and Health	25	(Members of the public introduce
	6		8
	0		8
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1 2	-	1 2	
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	9		11
1	Abstentions?	1	subject matter experts together and get them in the
2	The minutes of January 20th are approved.	2	room and get the work done to determine what a
3	Our first item of business is a report by	3	credentialing standard is. And then on a rolling
4	Dr. Lind for the provider credentialing process.	4	basis, we're going to have our contractor put that into
5	DR. LIND: As we began the construction of	5	codification. And so when we look at test runs and
6	architecture of the new credentialing system and as we	6	getting this into a system, we'll have that ready to go
7	included the managed care organizations (MCOs) and	7	in a much shorter time than if we did it as a single
8	sister agencies, it became apparent that we were going	8	lump process. But we're still anticipating and I
9	to need to build the universe of provider types. I'll	9	just confirmed this two days ago that we're still on
10	remind you that we initially were going restrict the	10	time for March 2017 implementation date.
11	Phase 1 credentialing initiative to medical, dental,	11	And I'm happy to entertain questions on
12	and behavioral health providers. But it became	12	that.
13	apparent that we were going to need to build the	13	DR. SPITALNIK: Thank you so much.
14	universe of all provider types, not just the ones that	14	Any questions?
15	we were including because of the considerations that we	15	Sid.
16	were beginning to understand. It became also	16	DR. WHITMAN: In the end, if someone is with
17	impractical to make distinctions between providers that	17	an MCO, is the managed care company going to be
18	would be included in Phase 1 and those that would be	18	responsible for their credentialing?
19	included in Phase 2, because some providers types	19	DR. LIND: When you say in the end
20	straddled the line and it was very difficult to	20	DR. WHITMAN: Well, after March 2017.
21	determine what would happen.	21	DR. LIND: No. That's the State's purview.
22	Therefore, two months ago we made the	22	DR. WHITMAN: So then the managed care
23	decision that we were going to merge Phase 1 and Phase	23	companies will no longer be responsible for
24	2 and accelerate the anticipated December 2018 time-	24	credentialing?
25	frame for that to March of 2017. The previous Phase 1	25	DR. LIND: For credentialing. Contracting
	10		12
1	Go-Live of June 30, 2016 was canceled, as it did not	1	is still, obviously, within the plans' purview. We're
2	make sense to proceed with that. So we're going with a	2	not taking any of that decision-making away, but the
3	more ambitious agenda and I think one that makes a lot	3	verification, etc, is all going to be state-owned.
4	more sense in the long run.	4	DR. WHITMAN: Okay.
5	We will now include all fee-for-service	5	DR. SPITALNIK: Any other comments?
6	(FFS) and managed care provider types that will do	6	MS. BRODSKY: Karen Brodsky from Health
7 8	business with Medicaid, including the non-traditional provider types. We have since completed a series of	7 8	Management Associates. What is the difference between being a
9	meetings which included our sister agencies,	9	service provider-type and a managed care provider-type?
10	stakeholders, and the managed care plans so the	10	Where would there be differences?
11	managed care plans are the next phase. Sorry. And	11	DR. LIND: Whether the provider chooses to
12	we're identifying subject matter experts and licensing	12	participate with fee-for-service or with any one of our
13	entities and anyone appropriate to be part of the	13	all of our managed care plans. The provider can be all
14	discussion of what it is that constitutes a	14	six at this point.
15	credentialing standard for a provider type that have	15	Does that answer your question?
16	not yet had that defined. And I believe New Jersey is	16	MS. BRODSKY: Yeah. I thought you were
17	the first state that's going through this process.	17	referring to their specialties.
18	We're using fee-for-service provider types as our	18	DR. LIND: Oh. Sorry. The way that
19	start, so we're using specialty codes, provider types,	19	fee-for-service defines provider types is there's
20	and New Jersey specific identifiers.	20	several different layers. And unfortunately, they
21	When that process completes, we're going to	21	don't match up at all well, they match up partially,
22	be cross-referencing those fee-for-service types with	22	but there's definite disconnects between the way
23	managed care service types. And, we are well into that	23	fee-for-service defines a particular specialty or a
24	process, as well. I anticipate that we're going to be	24	particular type of provider and the way that an MCO
25	starting the meetings where we actually group the	25	would define that. We're going to be more of an

	13		15
1	additive process in certain cases. But when possible,	1	that they've established for their Medicaid populations
2	we're trying cross off those into a single entity.	2	and the progress that they have made so far.
3	Either way, it needs to be all-inclusive because we're	3	First up, we've got Mark Humowiecki and
4	talking about the universe of all of them, so we're	4	Renee Murray from the Camden Coalition of Health Care
5	going to need to do the best job we can on that.	5	Providers.
6	MS. BRODSKY: Thank you.	6	MR. HUMOWIECKI: Thanks, Tyla. Good
7	DR. SPITALNIK: Anything else?	7	morning, everyone. It's really nice to be here to be
8	Thank you.	8	able to share some of the work that we're doing in
9	What would be the next natural juncture to	9	Camden with everyone.
10	provide an update? Would it be the June meeting?	10	So for more than a decade, the Camden
11	DR. LIND: The next MAAC meeting.	11	Coalition of Health Care Providers has been convening
12	DR. SPITALNIK: Okay. Thank you.	12	the local health care community in a model just like
13	DR. LIND: Happy to do that.	13	the one that Tyla described. We help write the ACO law
14	DR. SPITALNIK: Thank you so much. I know	14	so it wasn't surprising when it came to certify that we
15	you have to get to another meeting.	15	actually qualified because we were already a membership
16	We're now going to spend a significant	16	non-profit that brought together hospitals, primary
17	amount of time in our agenda around the Accountable	17	care providers, social services, and the community at
18	Care Organizations (ACOs) that are being established.	18	one table to work together.
19	And we'll start off with Tyla Housman. And Tyla's the	19	Our hypothesis is that to deliver better
20	Senior Director of the New Jersey Health Care Quality	20	care at lower costs you actually have more
21	Institute (HCQI). She'll provide the introduction for	21	collaboration, not more competition within health care.
22	us.	22	We know that Medicaid costs are driven by a relatively
23	MS. HOUSMAN: Thank you.	23	small portion of patients with complex needs, but the
24	DR. SPITALNIK: All these slides that are	24	system isn't currently serving very well. These
25	shown will be posted on the Division of Medical	25	complex patients generally have multiple chronic
-	14		16
	14		10
1	Assistance website at http://www.state.nj.us/	1	illnesses, are more likely to have mental health and
1 2		1	
	Assistance website at http://www.state.nj.us/	_	illnesses, are more likely to have mental health and
2	Assistance website at http://www.state.nj.us/ humanservices/dmahs/boards/maac/ so they're accessible	2	illnesses, are more likely to have mental health and addiction issues, may have a history of trauma, live in
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	47	T	10
4	17	4	19
1	our patients so you can see how that plays out in day-to-day real life.	1	users of the hospital and get to them while they're in the hospital to deliver a structured intervention.
2	So the first point is that the ACO creates	3	On the research side, we brought together
4	greater connectivity between and among the many parts	4	data from across sectors, health data, law enforcement
5	of the delivery system. We have nearly 40	5	data, education data, homeless data, to get a better,
6	organizations that are members of the coalition. Our	6	more rich understanding of how individuals interact
7	Board is made up of key representatives from across all	7	with different systems and to start to design new
8	of those different healthcare stakeholders that I	8	programs to be able to serve high users of multiple
9	mentioned earlier. We came from a board meeting this	9	system.
10	morning. It's a really exciting place to have folks	10	And just on Monday, we were part of an
11	who traditionally see themselves as competitors	11	exciting program in South Jersey called the South
12	we've got Virtua and Cooper sitting together at same	12	Jersey Behavioral Health Innovation Collaborative,
13	table. They're not always getting along, but at this	13	which has really been taking a deep-dive look at the
14	table they collaborate and they work together, and we	14	behavioral health system in our region. And one of the
15	have created a space for collaboration and innovation.	15	major components of that was pulling together data from
16	Twice a year we convene the Chief Executive	16	three counties all of the hospitals encounters, there
17	Officers (CEOs) of all four hospitals in our coalition	17	are five major health systems in three counties, and
18	as well as the Federally Qualified Health Centers	18	analyzing them based on the behavioral health diagnosis
19	(FQHCs) to come together and talk strategy and do what	19	and seeing identifying more than 800 people who have
20	do we need to collectively re-shape the system.	20	hit each of five different health systems, across five
21	Each month, line staff from across all the	21	counties, and trying to understand their needs and
22	stakeholders come together for citywide care management	22	build new systems to collaborate across those five
23	meetings where they share new resources, they	23	health systems and new models that can better serve
24	conference difficult cases, and they become part of an	24	their needs.
25	organized community that works together and knows who	25	The third thing that the ACO does is that it
	18		
	10		20
1	to call when you have a patient with a complex problem.	1	20 really drives quality improvement. We have contracts
1		1 2	
	to call when you have a patient with a complex problem.		really drives quality improvement. We have contracts
2	to call when you have a patient with a complex problem. And just this month, the Coalition has	2	really drives quality improvement. We have contracts with Medicaid Managed Care Organizations (MCOs), both
2	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	2 3	really drives quality improvement. We have contracts with Medicaid Managed Care Organizations (MCOs), both United Healthcare Community Plan and Horizon NJ Health.
2 3 4	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	2 3 4	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
2 3 4 5	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	2 3 4 5	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
2 3 4 5 6	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	2 3 4 5 6	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
2 3 4 5 6 7	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	2 3 4 5 6 7	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
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	21		23
4	they need are being well managed.	4	
1	That has had a dramatic result over the year	1	will help us to be able to scale the programs and
2		2	continue to fulfill the promise of innovation and
3	and a half that we've been doing our Seven-Day Pledge.	3	community organization.
4	We've seen the rate of people coming out of hospitals	4	So at this point I'm going to turn it over
5	and getting into primary care within seven days go from	5	to Renee to tell the story of one of our patients.
6	roughly 17, 18 percent when we started to nearly 40	6	MS. MURRAY: Thanks so much, Mark.
7	percent consistently now. And so that is starting to	7	Good morning, everyone.
8	drive improvements around re-admission and really	8	"A place. I need a place of my own. I'm
9	helping to deliver on the goal of keeping people out of	9	sick and tired of these streets and living like this.
10	the hospital if they don't need to be there.	10	Church, God still loves me. Getting my health back on
11	Fourth, the ACO provides care coordination	11	track. This is painful. Getting clean. I'm still
12	for complex patients. Renee will talk about one	12	using heroin and I want to get linked up to a program."
13	patient who we've worked with, a patient who's fairly	13	Those are direct quotes from our patient
14	typical in terms of the complexity of needs. Our	14	Angela who we have been working with for some time now.
15	nurses, community health workers, social workers,	15	These direct quotes were from a conversation we had
16	collaborate in a time limited intervention to try to	16	with her three years ago. And at that time, those
17	engage them in a relationship, a healing relationship	17	priorities and goals that she was listing there in her
18	that motivates people, uses motivational interviewing	18	quotes, the Coalition wasn't really equipped or had the
19	and other behavioral health techniques to engage people	19	tools and the resources to really help her accomplish
20	in their own care, to empower them and connect them to	20	the things that she was verbalizing the first time we
21	the rich array of services that exist in the community.	21	met her. That was prior to the ACO, prior to a lot of
22	And finally, the ACO is a platform for	22	innovation and collaboration of community partners. So
23	innovation. So as we do the care coordination, as we	23	three years ago we had this conversation with Angela.
24	work with complex patients, we see that there are	24	So Angela is a 57-year-old woman, a Camden
25	certain types of services that aren't available that we	25	City resident. She's living with Chronic Obstructive
	22		24
1	need new models of care. So in Camden, we've gotten	1	Pulmonary Disease (COPD). She's oxygen dependent,
2	need new models of care. So in Camden, we've gotten into housing and actually have launched a Housing First	2	Pulmonary Disease (COPD). She's oxygen dependent, hepatitis C, asthma, depression, bi-polar disorder,
2 3	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	2 3	Pulmonary Disease (COPD). She's oxygen dependent, hepatitis C, asthma, depression, bi-polar disorder, battling a heroin addiction for 30-plus years using
2 3 4	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	2 3 4	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
2 3 4 5	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.	2 3 4 5	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
2 3 4 5 6	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	2 3 4 5 6	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
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	25		07
1	25	4	27
1	Angela through this intervention, through this workflow	1	other and have universal care plans and really have an
2	with some pretty staggering results. Circle back to the HIE that Mark talked	2	idea of what Angela is doing, what is she working through, where is she today, what's the next step
4	about, Health Information Exchange. That really led us	4	tomorrow, what are we all working towards together.
5	to the Angela. It was the data that led us to her. It	5	So all these pieces came together for
6	was the communication, the real-time data feeds that	6	Angela. And the outcomes are fantastic. She hasn't
7	were coming in from the hospital systems that say, hey,	7	used heroin in over 60 days. She's on a Suboxone
8	Angela is sitting here in the ED. This is a great	8	program. She has a very strong relationship with her
9	moment for us to go over and begin to build our	9	primary care provider. She is seeing a counselor and a
10	relationship. So the Health Information Exchange and	10	psychiatrist who is managing her medications for
11	the data piece were driving us to meet her. That	11	depression and bi-polar disorder. She was just housed
12	started the relationship.	12	on Monday into her own apartment that also comes with
13	Once the team started working with her, we	13	the services of a registered nurse and a caseworker for
14	had the prompt re-connection back to primary care	14	the entire duration that she's on this Housing First
15	provider (PCP) with the Seven-Day Pledge, so that	15	voucher.
16	allowed Angela to get back into her primary care	16	I moved her in on Monday. And just seeing
17	doctor's office with accompaniment from our team to act	17	her in this new light I used to see her every day on
18	as a support, to act as an advocate, to act as a model,	18	the street, and that was normal. There was Angela, she
19	to really have a good dialog and conversation with the	19	was on the street on the corner that she was always on
20	primary care physician. And that really triggered the	20	with her oxygen tank. And to be able to see her move
21	whole spiral of the intervention. It allowed the	21	from where we were three years ago and that's
22	primary care doctor to really start to learn Angela's	22	another thing. It took three years to get there. It
23	story, not only that Angela has COPD and Hepatitis C	23	wasn't just overnight.
24	and she has asthma and needs oxygen, but what else	24	Like I said, the three years prior to that,
25	makes up Angela. How about that she has been using	25	we really didn't have the collaboration. We didn't
	26		28
1	heroin for 30 years and it's something that she's been	1	have everybody around the table really working to one
2	heroin for 30 years and it's something that she's been battling with and she has realized her desires to get	2	have everybody around the table really working to one unified mission. But now that we do have that, this
2 3	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	2 3	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
2 3 4	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	2 3 4	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
2 3 4 5	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	2 3 4 5	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
2 3 4 5 6	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	2 3 4 5 6	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
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	29		31
1	innovation that we have the opportunity to have at the	1	sort of as a facilitator that will provide the
2	Coalition with the ACO.	2	communication to all of those folks. And we're really
3	Thank you.	3	excited about that opportunity because it will be
4	DR. SPITALNIK: Thank you.	4	something maybe a little bit different for New Jersey
5	(Applause.)	5	and provide the State perhaps a different experience to
6	MS. HOUSMAN: Next up we have Colleen Woods	6	evaluate, which I think is in the spirit of the law.
7	from the Healthy Greater Newark ACO.	7	We've looked at some data. The Medicaid
8	MS. WOODS: Thanks, Tyla. It's good to see	8	claims data was provided to the ACOs in February, and
9	all of my old friends. I'm a former colleague of the	9	that really helps. Its unbelievable when you start to
10	Department of Human Services, which is just a	10	really look at the data. You know, you know what you
11	tremendous place to work and I'll never forget my time	11	know every day, but when you look at the data,
12	there.	12	sometimes you see those surprises that say, here's a
13	So, I also would like to extend my thanks to	13	population, you know, this is a population health
14	Meghan and to Val for the support of the ACOs. Just	14	issue, there's a population that we can't ignore. For
15	really can't find a better partner than Medicaid. They	15	Newark, it is clearly the high utilizers. There are
16	are so willing to help us through all of these legal	16	significant costs and populations in that rising risk
17	issues in terms of the implementation and data, sharing	17	category, you know, before they become high utilizers.
18	data, and all of the financing part. And we really	18	And there's also a large number of pediatric high
19	appreciate your support and look forward to	19	utilizers in Newark.
20	implementing something really remarkable in New Jersey.	20	We were fortunate in Newark to have a grant
21	I also want to thank my colleagues from	21	to start a small pediatric pilot. And it's amazing to
22	Camden and from Trenton who are so supportive of	22	see us work on behavioral health issues in our children
23	Newark, because as you'll see from the Newark	23	in our urban areas. And that's something we really
24	presentation, it's vastly different than Camden. So	24	want to try and focus on.
25	thank goodness we have Camden's early innovation. And	25	The diseases are listed down at the bottom
	30		32
1	those of us in Newark who are just starting really at go are looking to Trenton and Camden to sort of guide	1	that we're focusing on. So I'm giving more deeply. Thanks to Mark for giving that allover conceptual.
3	us but also create something new. And that's what I	3	We're sort of down in the weeds in Newark and so we've
4	kind of want to present to you today, what the	4	got to implement this shortly. So we're focused on
5	landscape looks like in Newark and where things are	5	setting up our model to coordinate care.
6	different than when Camden started. Is it 6 years?	6	This is thanks to my friend, Dr. Jim Walton
7	Maybe three or four years of the ACO kind of work.	7	who works in Dallas, Texas. He created this ACO model
8	Think of how much we've changed since then. There have	8	several years ago. It's probably one of the simplest
9	_		
	been so many grants focussed on care coordination. The	9	descriptions of an ACO I've ever seen, and I can apply
10	been so many grants focussed on care coordination. The federal government gives grants to our behavioral	9 10	
10 11		-	descriptions of an ACO I've ever seen, and I can apply
	federal government gives grants to our behavioral	10	descriptions of an ACO I've ever seen, and I can apply it over and over again. His idea is that we want to
11	federal government gives grants to our behavioral health groups. The program has brought care	10 11	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
11 12	federal government gives grants to our behavioral health groups. The program has brought care coordinators into the hospitals. And so where Camden	10 11 12	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
11 12 13	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	10 11 12 13	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
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	33		35
1	families. And, you know, this is a place we can't	1	the conditions in your populations. Newark is focused
2	forget and need to focus on.	2	on three zip codes. Newark is our largest city in New
3	So the trends that we've kind of seen	3	Jersey. The ACO is focused just those three zip codes
4	through our friends at Rutgers Center for State Health	4	that surround St. Michael's, Newark Beth, and
5	Policy and their tremendous work on the reports and	5	University Hospital. And so we took a look at what
6	looking at data as well. In Newark, in particular, we	6	conditions people are coming in for inpatient stays.
7	have the highest rate of readmissions. And, obviously,	7	And so you can see high utilizers, we think there are
8	that's a critical issue for hospitals. We hope to be	8	about 343 patients that we're going to be deploying
9	able to help our hospitals with that. We have the	9	that Camden high utilizer model. The median age is
10	third highest rate for avoidable hospitalization and	10	just 46 years old. And you can see 46-year-olds
11	the fourth highest rate for ED visits. This is the	11	already have significant diseases of the heart. Anemia
12	population health in Newark that we've got to focus on.	12	is typically associated with HIV, cancer, sickle cell
13	If we are able to resolve all of the	13	type problems. And the interesting thing is to see
14	problems or even a little bit, you know, you can see	14	schizophrenia, mood disorders, substance-related
15	the dollar amounts that are associated with these	15	disorders.
16	changes. This is the charge of the ACOs. This is what	16	There is no ignoring that the ACO work is a
17	we're hoping to do, is to be able to improve the	17	behavioral health work. There is just no way when you
18	quality of care we deliver and reduce some cost savings	18	look at the data to ignore that that is our challenge.
19	for the system.	19	And I think as Renee so eloquently said, it is not easy
20	Just to give you a sense of how we're sort	20	work, but this is the work that we're all committed to
21	of crafting the model in Newark. Again, the data is	21	do.
22	extremely important. I just brought a couple of slides	22	So just a couple other things that I would
23	to give you a sense of how you look at a population.	23	add in terms of what's unique about Newark. We are
24	We've got all kinds of views, but I think is remarkable	24	part of the Greater Newark Health Care Coalition that
25	in a way that you can see how large a population that 5	25	has been fortunate enough, like I said, the pediatric
	34		36
1	to 14-year-old is in Newark. I think that was one of	1	ACO grant to learn some of the work and begin to
2	the surprises that we saw. But, of course, there is	1 2	ACO grant to learn some of the work and begin to integrate all of the I would say the vertical
23	the surprises that we saw. But, of course, there is children's hospital at Newark Beth Israel, and so we do	2 3	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
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	37		39
1	pastors that they don't tell their doctors. The	1	think, that started in Camden with Dr. Brenner. And
2	community and where people feel safe is where we expect	2	it's one that's now grown, and I think is in a position
3	to leverage our community providers.	3	to distinguish New Jersey and to distinguish our
4	I talked about the pediatric focus. That	4	ability to care for our Medicaid beneficiaries in a new
5	pediatric focus, we hope, will also extend to a family	5	way.
6	focus. And then one of the other focus areas for the	6	Trenton Health Team started just over 10
7	Greater Health Newark Care Coalition is to deploy a	7	years ago. We were started by a catalytic event in the
8	grant from the Robert Wood Johnson Foundation on trauma	8	city when one of our two acute care hospitals systems
9	informed care. North Beth Israel is being trained	9	announced plans to close one of their facilities, when
10	under this grant for providers to understand the	10	Capital Health announced plans to close Mercer Hospital
11	effective of trauma on children's health. A child that	11	to build Hopewell, actually not far from where we're
12	experiences violence in the home or poverty or drug	12	currently standing.
13	addiction has a significant percentage of health	13	That need to understand the change in health
14	issues. I think most of you are aware of this work.	14	care delivery and figure out what the impact would be
15	We're hoping to bring that into our ACO work as well.	15	on the community was the event that brought our health
16	We have a Clinical Decisions Support Grant from the	16	care providers together. And today, our Trenton Health
17	Department of Health that is actually helping us use	17	Team organizations still is anchored by those four main
18	our HIE to deliver real time data into the practice	18	clinical partners: Capital Health and St. Francis as
19	offices. We want to be able to deploy alerts when one	19	the acute care hospital systems, Henry J. Health Center
20	of our patients gets EED, the same way Trenton and	20	as the FQHC that serves the Trenton community, and
21	Camden do that today. We want to be able to alert our	21	uniquely the City of Trenton through it's Department of
22	care team when there's a significant event, so we're	22	Health.
23	going to be using that grant to test that in Newark	23	So we have representations from city
24	Beth. We're about two or three months in on that	24	government and public health at the table every day.
25	project, and we'll begin to deploy that in July.	25	And that, for us, has given us a connection to the
	38		40
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1 2	And then we also are fortunate. New Jersey Innovation Institute is our technology provider.	1 2	people who can influence some of the other changes, particularly around social determinants that become so
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	41		43
1	2011-2012 was to address ER high utilization, not on an	1	clinical data coming to us from our providers, but also
2	individual level, but on a system level. And found	2	with claims data coming to us now from Medicaid. There
3	that our ER utilization in Trenton was 52 percent	3	resources and challenges available in each those data
4	higher than the national average. That's not	4	sets. By putting them together, we have both a
5	surprising, but it's happening because people are going	5	comprehensive picture of each patient and a more timely
6	to the ER for things that they should be going to their	6	view of each patient so that we can see, for example,
7	primary care provider, low acuity, non-emergent	7	who was in the ER yesterday.
8	utilization.	8	That let's us provide the second level of
9	So we brought in a consultant, Dr. Mark	9	service, which is the surveillance across the
10	Murray, who worked with our primary care providers on	10	population. So we provide a report on every morning to
11	what's called advanced access schedule. It's looking	11	our FQHC which of their patients was seen in the ER
12	at supply and demand for the provision of primary care.	12	yesterday or discharged from the hospital yesterday.
13	And we found there's a metric called third next	13	So their care managers don't have to go try to dig
14	available appointment. If you're the third person in	14	through records to try to find people. They can
15	line to call for an appointment, what appointment can	15	immediately know who do I need to reach out to bring
16	you get? It was as far out as three months for some of	16	them back into care to follow up.
17	our primary care sources. So there's no way we're	17	The third level is that individual patient
18	going to be able to get people to not to utilize the ER	18	record. And I heard a story yesterday morning from our
19	for some of these nonemergent needs if we can't connect	19	medical director. He was working with one of his
20	them to primary care.	20	colleagues at a primary care practice, a nurse
21	So over a course of about a year and some	21	practitioner. A patient came in with complaints of
22	very hard work, each of the three primary care sites	22	chest and abdominal pain that normally would have
23	brought down the third next available appointment for	23	suggested that practice would send the patient to the
24	their established patient panel to be able to offer	24	emergency department for care. The patient said,
25	same day or next day appointments to their established	25	"Well, I was in the ER yesterday," but the patient was
	42		
	42		44
1	patients.	1	44 in the ER at another system. They were in ER at Robert
1 2		1 2	
	patients.	_	in the ER at another system. They were in ER at Robert
2	patients. The other piece, there was provider	2	in the ER at another system. They were in ER at Robert Wood Johnson in Hamilton. The nurse practitioner was
2 3	patients. The other piece, there was provider continuity. In an outpatient clinic at one of hour	2 3	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.
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2 3 4 5	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	2 3 4 5	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
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	45		47
4		4	to achieve better health outcomes.
1	difficulty by the ER staff. He was also labeled as	1	
2	noncompliant. He would come in, he was argumentative.	2	We're very proud to have been selected as a
3	And after one inpatient admission, he was admitted to a	3	finalist for the Robert Wood Johnson Foundation
4	nursing home for follow-up care. He was actually	4	Cultural Health Prize. In fact, our site visit is next
5	discharged from the nursing home prematurely because he	5	week. And hopefully we're successful and it will be
6	threw tray of food at the staff, and the nursing home	-	the first New Jersey community to be recognized in that
7	couldn't retain him for safety reasons. He had	7 8	Way.
8	hepatitis C, HIV positive, he was on renal dialysis, and he weighed 90 pounds, as a 5 foot 6	0 9	We've had an investment from Trinity Health,
		9 10	a parent of one of our acute care hospitals systems,
10 11	early-40-year-old.	11	St. Francis, as part of their Transforming Communities
12	We did work with him, managed to connect him	12	Initiative where they are funding policies, systems,
12	into care, connected him the program at the Federally	12	and environment change in the Trenton community to try to improve health outcomes. So these project is a
14	Qualified Health Center (FQHC), gave him some of the	13	tremendous opportunity statewide for us to look broadly
	supports and the social supports and behavioral supports to allow him to stabilize. He came back to us		
15 16	a few months after graduation and asked how he could go	15 16	at what's driving the high cost and poor outcomes.
17	-	17	I'll end with one more story. We also are
18	back to the ER to apologize to the staff. He weighed 140 pounds. He said very frankly, "I thought I was	17	participating with our colleagues at Camden and Newark in the Faith and Prevention Program funded by the
19	dying and I was scared and I didn't know what to do	19	Department of Health. It implements a curriculum
20	with it."	20	called Faithful Families Eating Smart Moving More,
20		20	around healthy eating and healthy activity. And we had
22	And from a clinical perspective, he's no longer on renal dialysis. He actually managed to come	22	a young lady who participated in one of the programs.
23	off dialysis.	23	She was 14 years old and weighted 208 pounds, very
24	So the cost savings, not to mention the	24	quiet, sat in the back. She was the first one there at
25	incredible impact on this man's life, I think, speaks	25	each program and the last one to leave each night. By
20	46	20	48
1	to what we can do when we take a more holistic view and	1	the end of the six-week program, she had lost 15
2	when we take some time with these really complex	2	pounds. And at the three-month follow-up, she had lost
3	challenging patients to wrap our head around what they	3	90 pounds.
4	truly need and meet them where they are and provide	4	So her ability now, her confidence had come
5	those services.	5	back out, she was outgoing, she had actually brought
6	We're very pleased that a week from Monday	6	some of the principles back into her home. So it
7	we're going to be starting our partnership with	7	transformed her and for her family. And to speak back
8	Amerigroup. It's been a wonderful relationship so far,	8	to health care outcomes and health care costs, a
9	looking at what we can provide as a community-based ACO	9	280-pound 14-year-old is going to have a very different
10	and what Amerigroup can provide as a Managed Care	10	health status over the course of her lifetime than she
11	Organization and where we can support each other in	11	is now.
12	achieving the aid to the demonstrate project and to	12	So I appreciate all your time. And I thank
13	each of the Managed Care Organizations overall in	13	you.
14	providing better care for the beneficiaries.	14	(Applause.)
15	The other piece I think is unique the	15	DR. SPITALNIK: If the MAAC has questions
16	ability for these non-profits to seek out and receive	16	for any of the speakers, could we go to them first and
17	investment in community. And while this isn't what	17	then open it.
18	achieves a short-term cost savings or outcome change, I	18	Beverly.
19	think a lot of the utilization patterns, the cost we	19	MS. ROBERTS: Hi. First of all, you were
20	see, come from longer-term environmental and social	20	all terrific, so thank you very, very much.
21	challenges that we're dealing with. So we've sought	21	This is particularly to Colleen because she
22	out and received more than \$12 million funding over the	22	emphasized the young agers of the people, but this
23	10 years of making cultural change, system change,	23	could pertain to anybody if you're seeing a lot of the
24	policy change, and environment change to enable the	24	younger people.
25	residents of Trenton to better manage their health and	25	I was just wondering, Colleen, is one of

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1	your partners Special Child Health Services up in Essex	1	challenges I think we're all facing as a state is how
2	County?	2	long is the time from intake to real treatment for
3	MS. WOODS: I don't recall that. It was	3	those who have addiction issues, particularly detox and
4	Strong Healthy Communities Initiative Grant that	4	rehabilitation. Could you talk about, first of all,
5	provided that initial grant funding, and we're	5	what are those times to treatment? What are the
6	evaluating the data now. And then hopefully we'll vote	6	challenges you're facing in getting people the
7	to be able to bring the program.	7	resources they need for such treatment? And most
8	MS. ROBERTS: Because that's a free service	8	importantly, how are you collecting data which can
9	through the Department of Health. Special Child Health	9	demonstrate how long is this waiting time so we can
10	Services is in every county. I'm sure Mary is very	10	help to address it?
11	familiar with them. And they provide case management	11	MS. MURRAY: That's a great question. And
12	for up to 21 years old. They can connect to early	12	it is something that in Camden that we are the
13	intervention services and particularly emphasize autism	13	resources that we are struggling with. So, for
14	spectrum disorder or intellectual disability. But	14	instance, we have numerous patients on our panel who
15	there's perhaps a likelihood that there's some	15	are living with addiction. And when we link them to
16	undiagnosis among the little ones where if they were	16	detox and rehab, which I'm sure a lot of you know, the
17	diagnosed and if they were connected to Early	17	main issue is that when you go to detox, a rehab bed
18	Intervention quickly, that that could help to minimize	18	doesn't open up right when you're done detox. There's
19	the level of disability.	19	always a lag in between.
20	MS. WOODS: I'd love to get a contact name	20	So to answer your question about time frame,
21	from you if you have one.	21	we work with mainly three detox in rehab institutions
22	MS. ROBERTS: Sure.	22	in the state. And we're always about a two to
23	DR. SPITALNIK: I would also want to add on	23	three-week lag out to get some into detox. And then
24	that from a surveillance point of view that in terms of	24	once they're in detox, they're there for five days, six
25	health information, the birth defects registry, the	25	days, eight days. The unfortunate thing is, we've
	50		50
	50		52
1	electronic birth certificate, and the autism registry	1	52 never been successful of going from detox to rehab.
1 2		1 2	
	electronic birth certificate, and the autism registry would be very helpful in a predictive way. MS. WOODS: One of the best things that we	_	never been successful of going from detox to rehab.
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	53		55
1	at least two times on one shift, I believe is what it	1	Newark, we're going to begin to work with Care Plus and
2		2	
	was. I can't speak to the deaths statistics, but, obviously, it is an issue of the lack of resources for	2	with Bergen Regional to be able to provide to see that. The first thing we need to do is see what's happening
3			
4 5	that.	4 5	and then begin to measure the data. So I do think
	MR. HUMOWIECKI: This is a huge challenge. It's true on the substance use side, it's true on the	6	there is a ray of hope in terms of breaking down those barriers.
6	psychiatric side. People go inpatient, they come out,	7	MR. HUMOWIECKI: I would say there's also a
7 8		8	real interest in the data. The easiest data for us all
9	there are no services, they relapse. A major push when we've had strategic meetings with our Board has been	9	to get at the beginning was from hospitals. But now
10	how do we fund more of these services? And so that's	10	
11	the second Suboxone provider, very recent, just the	11	we're moving into the space of working with our behavioral health providers and starting to get their
12	last five months, we're looking to try to expand that	12	clinical data in. They're using our HIEs now. And so
13	throughout primary care within Camden. Same thing on	12	there are New Jersey specific laws that make that more
14	the behavioral health side, and that's part of I	14	challenging. There are federal rules, Part 2 around
14		14	
16	mentioned the South Jersey Behavioral Health Innovation	16	substance use treatment that made clinical data sharing
17	Collaborative, trying to just expand the amount of resources that are available because it's a five-week	17	more difficult. Those are all things that are, hopefully, being overcome through the HIEs and other
18	waiting list inpatient psych to get into outpatient	18	efforts. So there is hope down the line.
19	treatment, and people are relapsing. So all the data	19	MS. HOUSMAN: Questions? Sir?
20	around all the cost savings from avoiding readmissions	20	MR. CASEY: Kevin Casey, New Jersey Council
20	fall by the wayside if you can't connect that service.	20	of Developmental Disabilities.
22	So a really important comment. Thank you.	22	I'm curious as to whether you have any
23	MR. PAULSON: And I think you're also	23	developmental disabilities providers involved in your
24	hearing from an anecdotal and individual patient	24	local network and coordination in your local network.
25	experiences or aggregated individual patients, not	25	I ask that because as the population focuses on
	54		56
1	truly a measure from the data on the entire community.	1	
			Oevelopmental disability, it's not universal put they
2	We do not vet have that measure either. It's a	2	developmental disability, it's not universal but they certainly have a tendency for more complex medical
2	We do not yet have that measure either. It's a difficult one to find in these data sets.		certainly have a tendency for more complex medical
2 3 4	difficult one to find in these data sets.	2	
3	difficult one to find in these data sets. I can also give you a patient story, a	2 3	certainly have a tendency for more complex medical issues than the general population. That's one
3 4	difficult one to find in these data sets.	2 3 4	certainly have a tendency for more complex medical issues than the general population. That's one question.
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	57		59
1	in getting more involved.	1	in certain zip codes, right, is it strictly zip codes
2		2	in Trenton, Camden, and Newark?
	Ev Liebman, who is on our Board, lead a		MS. WOODS: Yeah.
3	group that formed a Community Advisory Council. The	3 4	MR. VIVIAN: Are there any plans for this to
4 5	fourth Thursday of every month, a group of 30 Camden residents come together and talk about the strategies	4 5	expand outside of those somebody who lives and
6	of the Coalition of the ACO, talk about hot topics that	6	operates in Jersey City, Hudson County, we don't really
7	they're really interested in, pushing us to be more	7	have those issues that people living in the more
8	responsive to the community. They go out and they	8	suburban areas and more of the rural areas, if New
9	connect the Coalition back to their own churches,	9	Jersey has any rural areas, but of accessing a primary
10	schools, local communities. So it's been a really rich	10	care provider. We have clinics and different things
11	sort of bidirectional relationship with our community.	11	like that. Do you have trouble recruiting primary care
12	We now have Board seats and Executive	12	providers, like private primary care providers?
13	Council seats that are filled by members of the	13	I just wonder if are there any plans to
14	community who are elected by this Community Advisory	14	expand this to areas where it's more difficult for a
15	Council. That's happened over the year and a half, two	15	consumer to access primary care providers and all those
16	years. And it's been incredibly invigorating for the	16	kinds of services. Because the urban areas are a
17	organization to have the people of Camden, the	17	little easier.
18	nonprofessional, the consumer voice right at the table	18	MS. DAVEY: So this was legislated, so we
19	alongside the professional, alongside the CEO. It's	19	have three certified ACOs. These actually qualify to
20	made a huge difference.	20	meet that legislative intent. But there's always talk.
21	MS. WOODS: We're obligated as part of the	21	We have ACO-like models throughout the State. They're
22	legislation to engage. Medicaid smartly put that into	22	not part of this legislation, per se. But absolutely,
23	the legislation. I will agree with you that the data	23	there are these ACO-likes throughout the New Jersey.
24	that we've looked at in conversations with our payer	24	And then as we look to see if the pilot is working,
25	partners, our DDD members and patients are high	25	sustainable, it's something that we can pursue and
	58		20
	58		60
1	oo utilizers. There's just no doubt about that. And so I	1	going statewide.
1		1 2	
	utilizers. There's just no doubt about that. And so I		going statewide.
2	utilizers. There's just no doubt about that. And so I think gathering that data helps us talk to other	2	going statewide. MR. VIVIAN: Because like I said, there are
23	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	2 3	going statewide. MR. VIVIAN: Because like I said, there are areas that more difficult. This would be more helpful
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1	unless there's one more question.	1	discovery tool called our person center planning tool,
2	Well, on behalf the Quality Institute, on	2	so we had to again get that in place and running. And
3	behalf of the ACOs, we want to MAAC and thank Meghan	3	it's always done with a new care management model,
4	and Valerie and the rest of the staff at Medicaid,	4	which is support coordination. It's a little bit
5	Phyllis who helped bring us here today and set this all	5	different from the case management that had been at DDD
6	up for us. We really appreciate the opportunity.	6	for a long time.
7	(Applause.)	7	So we've been working on getting all those
8	DR. SPITALNIK: Thanks to all of you for the	8	pieces in place. They've all been in place for a while
9	work you're doing and bringing it to us and inspiring I	9	now. And we actually last summer enrolled our first
10	us. We look forward to continuing to hear about your	10	cohort, fully enrolled them into the Supports Program.
11	progress and to provide support.	11	We kept it pretty small at the beginning.
12	We're going to turn to the section of our	12	We enrolled about a hundred people or so because it was
13	agenda that focuses on informational updates. And I'd	13	brand-new program. Our providers were going to be
14	like to call on Liz Shea, the Assistant Commissioner	14	operating in a completely new fee-for-service
15	for the Division of Development Disabilities of the	15	environment that they had not been operated in. There
16	Department of Human Services to talk about the Supports	16	were new services, new rates they were using. So with
17	Program.	17	so much change they are were going to be billing
18	Liz, welcome.	18	directly into the Medicaid system. So with all that
19	MS. SHEA: Good morning. Thanks for having	19	change, we kept it, like I said, small so we could
20	me. I think this is probably maybe my third or fourth	20	really kind of watch it as issues arose, address them
21	in a row MAAC meeting that I've been at discussing sort	21	quickly before we grew larger.
22	of an update on the Supports Program and where we are.	22	So we closely monitored. We had a Supports
23	So to the degree you're all getting tired of it, I will	23	Program workgroup that met biweekly, mostly on the
24	start with the good news is I actually have new exiting	24	phone, but biweekly to talk about things that were
25	news about the Supports Program today. I want to just	25	coming up. Any issues that popped up, we were able to
	62		64
	02		64
1	oz again, like I always try and do, take a quick step back	1	64 kind of immediately address them.
1 2	again, like I always try and do, take a quick step back and just explain what the Supports Program is, again,	1 2	
	again, like I always try and do, take a quick step back		kind of immediately address them.
2	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	2	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
2 3	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	2 3	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
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	65		67
1	or so people who are somewhere in that cohort, that	1	automated in the system.
2	second cohort, that are somewhere in that enrollment	2	Again, it's a very small group, but for
3	process along what way, so not fully enrolled but they	3	those of you who are not familiar, this is a group of a
4	should be relatively soon.	4	couple right now we have a 120 in the State that we
5	The exciting new news, two things. One is	5	know of, but maybe a couple will age out every year
6	that the Supports Program amendments that we worked so	6	into the system. But someone that will age out of
7	hard on and I know I talked about here and many	7	their school system who needs private duty nursing, but
8	people actually in this room really helped from an	8	other than the fact that they need private duty nursing
9	advocacy perspective, and certainly from a State	9	would be able to very much benefit from the employment
10	perspective on the technical work of kind of getting us	10	and day and other services that DDD has to offer. And
11	there. I know people worked really hard. So the	11	previously we've been sort of saying you either have to
12	amendments to the Supports Program were approved by CMS	12	go completely to MLTSS and you couldn't be in the DDD
13	on February 11th. And again, just to sort of summarize	13	system, or only come here and then you can't access
14	some of them real quick for those of you who might not	14	your PEN, which obviously people need. So there was
15	be familiar. We changed the eligibility to say you	15	that was that weird sort of gap in the system. So
16	have to at least 21 only. It had previously been that	16	we're really very happy that we've managed to work that
17	you have to be 21 and have exhausted your educational	17	out.
18	entitlement. What we were finding is that we had	18	And then there were a couple of technical
19	people sort of during the course of that last year who	19	amendments just removing references to certain states
20	were aging out of the DCF system because they can't	20	and transportation and some other things that community
21	hold them after 21 who just were maybe in school but	21	asked for.
22	for respite for the other services they needed during	22	So we're thrilled the amendments were
23	that year they needed to access them somewhere. So	23	approved. And, again, we're working through a full
24	there had been this gap. So we lightened up on that.	24	implementation of them now. But as people present, we
25	CMS agreed.	25	are able actual enroll people sort of if need be.
	66		68
1	Very exciting. We added two new Medicaid	1	The other kind of major announcement around
2	Very exciting. We added two new Medicaid categories which allowed us to address an issue that	2	The other kind of major announcement around the Supports Program is that beginning essentially now,
23	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	2 3	The other kind of major announcement around the Supports Program is that beginning essentially now, starting this month in April, all new presenters,
2 3 4	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	2 3 4	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
2 3 4 5	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,	2 3 4 5	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,
2 3 4 5 6	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	2 3 4 5 6	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
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	69	1	71
1	mean they wouldn't be served. They would get the same	1	steering them into sort of our interm system.
2	services from DDD that people have been able to always	2	If it's not something that we can't do now,
3	get historically. We just won't put them directly in	3	though, and there is an adequate provider network, we
4	the actual Supports Program yet.	4	are expecting people to sort of enroll directly in. So
5	That's pretty much my update. I'll take any	5	I wouldn't go so far as to say you know, it's not
6	questions anybody has about it.	6	like everyone coming out we'll say, "You have a choose,
7	DR. SPITALNIK: Beverly.	7	you can be Supports Program or not." The idea is that
8	MS. ROBERTS: Thank very much, Liz.	8	people will enroll directly in the Supports Program
9	With your last point about everyone coming	9	unless they have one of these needs that can't be met
10	in, the new graduates coming into the Supports Program,	10	there.
11	how will that impact the non-DACs who are going to be	11	MS. LIBMAN: Thank you. And the second
12	coming who are going graduate?	12	question is: What is the turnaround from the time that
13	MS. SHEA: The non-DACs that we know of	12	a provider and my application to Medicaid, what is the
14	today, again, that are not new presenters, who are	14	turnaround time for that usually.
15	already in our system, as we kind of get the implement	15	MS. SHEA: So that's a little bit hard to
16	down, we're working weekly on how to flip people into	16	say in that usually is different or has been along the
17	the Supports Program. But if there's a new person	17	way. So there was a period of time, I think, early on
18	that's a non-DAC, again, that comes in tomorrow, we'll	18	where we initially did a push trying to get all the DDD
19	look at them like anything else. If they otherwise	19	providers who had not previously been Medicaid
20	would go into the Supports Program, everything is met,	20	providers enrolled where I think things were taking
20	all the other of things in place, then we have	20	longer. I mean, they were taking longer both on DDD's
22	workarounds in place that we would be able to enroll	22	side as we were sort of reviewing things because it was
23	them directly right away as they come out of school.	23	new to us, and then also at the Medicaid side. In
24	We would be able to do that. But won't probably be	23	general, both were taking longer.
25	flipping the group. Again, there's 120 or 125 or so, I	25	The other thing I'll say, things are pretty
25		23	
	/0		72
1	70 think of them. We wouldn't be flipping that whole	1	72 quick now Things don't really sit on either side as
1	think, of them. We wouldn't be flipping that whole	1	quick now. Things don't really sit on either side, as
2	think, of them. We wouldn't be flipping that whole group necessarily wholesale right now. We're working	2	quick now. Things don't really sit on either side, as far as I hear. What we do sometimes still see is
2 3	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	2 3	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
2 3 4	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,	2 3 4	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
2 3 4 5	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.	2 3	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
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	70		70
	73		75
1	MR. CASEY: This is more a comment than	1	share with them the rates, to share with them the
2	question. There are very few states that have made the	2	underlying principles and development of the rates, and
3	level of commitment that DDD is making here in terms of	3	to lay out what they can expect going forward.
4	picking up all graduates. I know there are a few	4	Since February, we've had well over 25 hours
5	caveats. That's tremendously important to the system	5	that we have spent in meetings with our stakeholder to
6	over time. And I think that the Department deserves	6	process the rates and the transitions.
7	congratulations on that. It's really an important	7	One of the good news pieces that's in our
8	commitment that will make the system as a whole better	8	rates is the true up, what we refer to as the true up.
9	over time. I think that has to be noted.	9	What that means is that when the decision was made for
10	MS. SHEA: Thank you. We love	10	New Jersey to expand Medicaid eligibility, that
11	congratulations.	11	individuals who have a substance use disorder who were
12	DR. SPITALNIK: Thank you very much. But	12	originally in Plan A, they continued to have
13	I'll add our congratulations, and we look forward to	13	availability to services through Medicaid reimbursement
14	either in the June or the fall meeting finding out how	14	for detox services. But for individuals who became
15	things have gone with the new graduates. Thanks so	15	eligible for Medicaid through the true up, there were a
16	much.	16	Host of other services that were available to them that
17	(Applause.)	17	included outpatient services, intensive outpatient
18	DR. SPITALNIK: We now turn to an	18	services, short-term residential services, detox
19	informational update on Behavioral Health Services.	19	services, and those services through Medicaid
20	And I'm please to welcome again Valerie Mielke, who is	20	reimbursement were not available to individuals who
21	Assistant Commissioner for the Division of Mental	21	were in Plan A.
22	Health and Addiction Services.	22	Come July 2016, with the true up, those
23	MS. MIELKE: Good morning. Thank you very	23	individuals who are in Plan A are going to be eligible
24	much for having me here today. It's really to talk	24	for the same Medicaid services for reimbursement for
25	about our rates. It's a really significant initiative	25	individuals who are part of the expansion program. The
	74		70
			76
1	that we're undergoing here in our Division.	1	rates will be the same and the services that are
2	that we're undergoing here in our Division. As many of you know, Governor Christie	2	rates will be the same and the services that are available will be the same, as well.
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1	assertive community treatment rates, particularly as it	1	required in order for our providers to bill Medicaid,
2	relates to the State rate that we struck.	2	as well as bill the for State dollars for services that
3	What we are hearing and what we found in	3	they would like to provide. And so those training
4	looking at information from our providers is that	4	sessions have already commenced.
5	Medicaid eligibility for individuals who enrolled in	5	We are also going to be convening a Mental
6	our packed programs that those ratios are significantly	6	Health Provider Advisory Group. And that group will
7	lower than what we see in our broader services. And so	7	work with us as we begin to we are currently
8	we actually just recently issued a correspondence to	8	building a mental health application to collect client
9	our providers to equalize the State rate to the	9	specific encounters on the State side in terms of
10	Medicaid rate. And that correspondence was issued a	10	reimbursement. And so we will be working with a small
11	couple of days ago.	11	group of providers to help to not just develop that
12	Based on the feedback that's coming in from	12	interface, but also to provide us with feedback as they
13	our providers, we're continuing to do our due	13	test that interface to identify if there are any
14	diligence, continuing to collect some data and	14	issues, challenges related to that so that we can make
15	information from providers who are submitting that to	15	sure that interface is ready for rollout come January
16	us, evaluating that information, and looking at the	16	when the mental health services State dollars go
17	rates. So I would anticipate that you will continue to	17	fee-for-service.
18	hear information and feedback from us as this process	18	One other thing that we are doing this is
19	continues to unfold, which leads to me communications.	19	in partnership with Medicaid is presumptive
20	We current have on our website the	20	eligibility training. So we issued a survey out to our
21	PowerPoint presentation that we presented to our	21	providers to assess interest in participating in
22	providers in February and March related to the rates.	22	training and certifying staff within their
23	We've been updating that PowerPoint as we have been	23	organizations to be able to process and identify
24	changing information and as that becomes available. In	24	individuals as being presumptively eligible for
25	addition to that, we also have on our website a link to	25	Medicaid. The advantage to the provider is that as
	78		80
4	Vou Tubo videoc for the precentations that were		individuals are referred and coming into their system
1	You Tube videos for the presentations that were	1	individuals are referred and coming into their system,
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	81		83
1	have and I think other people in the developmental	1	initially for individuals who are in support of
2	disability community have as well. So going back, and	2	housing. So the draft regs were posted on our website.
3	I know you've only with the Division a relative short	3	We received comments and questions. We've actually
4	time, several years ago there was a dual diagnosis task	4	completed our response for the questions and comments
5	force appointed by then Commissioner Jen Velez. And	5	that were made. And now the vetting process for that
6	that met for quite a period of time. It was dual	6	has begun. So the regulations, I anticipate, will be
7	diagnosis for people with an intellectual disability	7	promulgated within the next couple of months. But we
8	and a behavioral health disorder. It met for quite a	8	just we need to go through that vetting process.
9	time and had a great report that was completed and	9	So as it relates Community Support Services,
10	presented to the Commissioner. And nothing really	10	and our providers along with our Division along with
11	happened with that. And then later there was going to	11	Medicaid, we've done a lot of prep work in preparation
12	be the ASO and BHO that was happening. And the	12	for the implementation or Community Support Services.
13	decision was that even the people with intellectual	13	We're continuing with those efforts so that once the
14	disabilities who currently, if they have a dual	14	regulations are promulgated, our providers are ready to
15	diagnosis, their behavioral health is from the Medicaid	15	begin to provide that service.
16	HMO, it's not in the fee-for-service world. And that's	16	MR. VIVIAN: We can't do CSS until the regs
17	the way it's been for a number of years. But the plan	17	are approved, though, right? We can't start to bill
18	had been to have those people leave the Medicaid HMO	18	Medicaid without the reg?
19	and be part of the new ASO or BHO that was discussed	19	MS. MIELKE: Yes, that's correct. You
20	for quite a period of time. And there was a separate	20	cannot bill Medicaid without the regulations being
21	workgroup from that was looking at dual diagnosis and	21	promulgated. You actually need to be licensed as a CSS
22	made very good recommendations. And now that's not	22	provider. So we have developed, along with our office
23	happening.	23	of licensing, an attestation form so that agencies
24	So I guess my question is with everything	24	don't have to wait licensing to come out to do
25	that's moving forward and the tremendous amount of	25	licensing reviews, but they will complete this
4	82		84
1	planning that's going into the non-DD population and I think Liz may not be here now. I was hoping to have	1	attestation form, submit it to Office of licensing. And our Division along with Office of Licensing will
3	both of you here at the same time to address this. And	3	review those documents and then agencies will be able
4	I know you can't give me an answer at the moment, but I	4	to be licensed as Community Support Service providers.
5	wanted to bring up that this is an area of very	5	And then once they're licensed, they will actually need
6	significant concern and to find out what we can really	6	to submit an application to Medicaid for the special
7	do to move this forward for this particular population.	7	program code to be able to specifically bill Community
8	MS. MIELKE: I'm happy to come back prepared	8	Support Services. So once of the regulations are
9	even to talk about some of the initiatives that in	9	promulgated, I imagine that it will be at least six
10	partnership that we have had with DDD to serve	10	weeks to two months before actual billing occurs.
11	individuals who are duly diagnosed. So since the	11	MR. VIVIAN: Okay. Thank you.
12	issuance of that report, there have been things that we	12	MS. MIELKE: You're welcome.
13	have worked through with DDD in terms of moving some	13	DR. SPITALNIK: Colleen.
14	initiatives forward. So I think maybe when you	14	MS. WOODS: Now, would you consider the ACOs
15	determine as appropriate, we can come back and we can	15	a provider? Can we potentially be a provider for the
16	really present and talk about what we've done as next	16	Presumptive Eligibility process?
17	steps. That would be helpful.	17	MS. MIELKE: I'll have to differ that to
18	MS. ROBERTS: Thank you.	18	Medicaid.
19	DR. SPITALNIK: Other questions?	19	MS. SMITH: Right now all the medical
20	Wayne.	20	providers can be
21	MR. VIVIAN: Any updates on when the regs	21	(Multiple speakers.)
22	are coming out, the CSS regs?	22	DR. SPITALNIK: I'm sorry. It's too small a
23	MS. MIELKE: The million dollar question.	23	conversation, so it needs to be louder, please.
24	The Community Supports Services is a new service that	24	Did people hear the question about the ACO?
25	will be available in New Jersey. We're rolling it out	25	The question was could the ACO be considered

1         a provider for Presumptive Eligibility,         1         repeat the last part, please?           2         And the answer was?         MS. ABRAMS: The second part was when we           3         MS. SSITH: The providers within the ACO         might expect communique from the Department or form the           4         can.         The specific communique from the Department or form the           5         DR. SPTLLINE: Josh Spielberg.         Foreixes of New Jersey.         The sounds like you're doing a lot of great           9         work in terms of communicating with providers and         The rew as going to be a provider advisor. I wonder do           10         interacting with providers. And I heard you say that         There was going to be a provider advisor. I wonder do           11         framiny members of consumers and advicacy groups         The spece advisory group that includes consumers and           13         broader advisory group that includes consumers and         The terms of the communication neargoing           16         In terms of the communication neargoing           17         is comprised of families and consumers, as well as           18         participate with us as it relates to the           19         participate with us as it relates on the advicacy group to help           20         communications going forwards           21         consprised of famil		85		87
2         And the answer was?         2         MS. ARAMS: The second part was when we           3         MS. SMITH: The providers within the ACO         and the answer was?         and the answer was?           4         Con.         Con.         Second Sec	1		1	
3         MS. SNITH: The providers within the ACO         3         might expect communique from the Department or from the           4         can.         5         DR. SPITALNIK: Josh Spielberg.         6         MR. SPITALNIK: Josh Spielberg.           5         MR. SPITALNIK: Josh Spielberg.         6         MR. SPITALNIK: Josh Spielberg.         6         MR. SPITALNIK: Josh Spielberg.           6         MR. SPITALNIK: Josh Spielberg.         6         MR. SPITALNIK: Josh Spielberg.           7         Services of New Jersey.         8         It sounds like you're doing a lot of great         9           9         wark in terms of communicating with providers and         9         Support Services rates in the PowerPoint.         9           10         interacting on providers are and provider actions going forw large years well as         9         and then there have been also some questions and           11         there was going to be a provider actions going forw large years well as         11         12         reases with the areas that were in the PowerPoint once           13         broader advisory group that includes consumers and         10         11         there was going to be a provider acting and direct microst most or movider areas         12         rease which near going to builts the powerPoint.         13           14         that was a part of ourustrates; bease a communications re				
4       can,       4       Division that they said will be forthcoming about their         5       DR. SPITALNIK: Josh Spielberg, from Legal       5       review of the Community Support Services rates?         6       MR. SPIELBERG: Josh Spielberg from Legal       6       MS. MIELKE: So in terms of the Community 4         9       work in terms of communicating with providers and       9       and then there have been also some questions and         10       interacting with provider advisor. I wonder do       9       and then there have been also some questions and         10       interacting with provider advisor. I wonder do       9       and then there have been also some questions and         11       there was agoing to be a provider advisor. I wonder do       9       and then there have been also some questions and         12       providers. We are taking individuals from that group       16       In terms of the communication regarding         15       forward.       16       In terms of the communication regarding         16       In terms of the communication regarding       17       communica advisor providers.         10       providers. We actualing utilize that core group to help       16       In terms of the communication regarding         12       providers. We actualing utilize that core group to help       20       So we understand that there's another				
5DR. SPTELBERG: Josh Spielberg, MR. SPTELBERG: Josh Spielberg from Legal Services of New Jersey.5review of the Community Support Services rates in the PowerPoint, there were and then ther have been also some questions and oncents about some of the rates that were in the PowerPoint. so me errors in the rates that were in the PowerPoint. and then ther have been also some questions and oncents about some of the rates that were in the powerfoint. So we've been really working on those there was be up now or do you have plans to set up a of you have set up now or do you have plans to set up a of you have set up now or do you have plans to set up a there was about some of the rates that were in the powerfoint. So we've been really working on those there was about some of the rates that were in the there was about some of the rates that were in the there was about some of the rates that were in the there was about some of the rates that were in the there was about some of the rates that were in the the about some of the rates that were in the the was a put of our strategic planning process hat the was about some of the rates that were in the the was about some of the rates that that that were the was about some of the rates that that that will the was about some of the rates that that that will the was about some of the rates that that that will the was about some of the rates that that that will the was about some of the rates that that that will the was about some of the rates that that that there's another to some understand that there's another to s			_	
6       MR. SPIELBERG: Josh Spielberg from Legal       6       MS. MIELKE: So in terms of the Community         7       Services of New Jersy.       Support Services rates in the PowerPoint, there were         9       work in terms of communicating with providers and       and then there have been also some questions and         10       interacting with providers. And I heard you say that       9         11       there was going to be a provider advisor. I wonder do       9         12       you have set up now or do you have plans to set up a       10         13       broader advisory group that includes consumers and       10         14       family members of consumers and advocacy groups?       14       what goes up on the website reflects how we're moving         15       that was a part of our strategic planning process that       16       In terms of the communication regarding         17       is comprised of families and consumers, as well as       16       In terms of the communication regarding         17       providers. We act taking undividuals from purpot Services that       17       Community Buppot Services that         18       boot within a week.       10       10       Se and then act, week.         19       to develop some communications to go ou to       25       Se and then act, week.         12       uoregarding that	-		-	
7       Survices of New Jersey.       7       Support Services rates in the PowerPoint, there were         8       some errors in the rates that were in the PowerPoint       3         10       interacting with providers. And I heard you say that       11         11       there was going to be a provider advisor. I wonder do       2         12       you have set up now of do you have plans to set up a       10         13       broader advisory group that includes consumers and       11         14       family members of communes and advocky groups?       15         15       ms. MIELKE: We have a communications group       16         16       that was a part of our strategic planning process that       17         18       providers. We are taking individuals from that group       15         14       to participate with us as it relates to the       20         20       communications going forward for families and for       17         11       providers. We are taking individuals from that group       18         21       to develop some communications to go ou to       20         22       communications going forward for families and for       17         23       using, obsaically Community Support Services that       20         24       Wayne spoke of for communications bag				
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11       there was going to be a provider advisor. I wonder do         12       you have set up now or do you have plans to set up a         13       broader advisory group that includes consumers and advocacy groups?         14       family members of consumers and advocacy groups?         15       MS. MIELKE: We have a communications group         16       In terms of the communication regarding         17       is comprised of families and consumers, as well as         18       providers. We are taking individuals from that group         19       to participate with us as it relates to the         20       communications going forward for families and for         19       providers. We actually utilize that core group to help         21       consumers and to providers regarding that. And we're         23       using, so basically Community Support Services that         24       Wave sopoke of for communications to go out to         25       consumers and tamilies, as well, to gather         3       In addition to that, I spoke about the         4       listening session. There will be a istening session         5       for consumers and tamilies, as well, to gather         6       additional information in from consumers. So we do         7       have a structure builtin. It is importantor us to      <	10		10	concerns about some of the rates that were in the
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1	MS. MIELKE: Thank you.	1	the northern region, and we're trying to address that
2	DR. SPITALNIK: Thank you so much, Valerie.	2	by reallocating some of the assessments for a
3	I appreciate it. And we will figure out what the best	3	particular MCO to the southern region so that we can
4	timing is around engaging the issue of people with dual	4	address it. So we are trying to be and I think we are
5	diagnoses of intellectual disability and mental health.	5	much more timely.
6	MS. MIELKE: Thank you very much.	6	If there are problems we have always said
7	DR. SPITALNIK: Thank you so much.	7	to, whether they're providers or individuals, to please
8	We have three more informational updates,	8	reach out to our northern or southern regional office
9	and we're going to start with Stu Dubin on Managed Long	9	and they will deal with that person with a one-to-one
10	Term Services and Supports and then go to Carol Grant	10	basis.
11	about Appeals and Grievances.	11	MR. VIVIAN: Okay. Because to go back to
12	I'd ask both of these presenters to somewhat	12	the managed care company, to the case management
13	abbreviate the information because I want to make sure	13	department, is not really proving to be helpful.
14	that we also get to the full update about FamilyCare.	14	Is there a number for the northern
15	So, Stu, welcome in this role.	15	department?
16	MR. DUBIN: Thank you. I'll be the first	16	MS. DAY: There is. I don't have it with
17	say the first to say good afternoon to everybody.	17	me. But I will make sure that we can send it and then
18	I think last meeting we showed about 18	18	everyone will have access to those numbers.
19	slides of MLTSS data information. We truncated that	19	MR. VIVIAN: Okay. So it's better than go
20	this meeting to about six. I'll run through them real	20	directly to managed care company again?
21	brief and quick. And if we need to build on those for	21	MS. DAY: Well, again, there's two different
22	future meetings we can.	22	processes. And I think that that's what we have to try
23	(Presentation by Mr. Dubin.)	23	to help resolve. And then through our quality
24	(Slide presentations conducted at Medical	24	assurance, our MLTSS quality assurance, they also deal
25	Assistance Advisory Council meetings are	25	directly with issues, which is Maribeth Robenolt. So
	90		
			92
1	available for viewing at http://www.state.nj.us	1	if there's particular problem with an MCO as opposed a
2	available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/.)	1 2	if there's particular problem with an MCO as opposed a problem with the State, then we can deal with it
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	93		95
1	those are new to system or people who were in managed	1	Robenolt.)
2	care, the managed care had recognition that they really	2	(Slide presentations conducted at Medical
3	might be MLTSS because they were getting PCA, by way of	3	Assistance Advisory Council meetings are
4	example, and so that there are people who transitioned	4	available for viewing at http://www.state.nj.us
5	from one kind of Medicaid to MLTSS?	5	/humanservices/dmahs/boards/maac/.)
6	MR. DUBIN: It's the transition. It's folks	6	DR. SPITALNIK: Thank you.
7	working their way through the managed care from being	7	Josh.
8	just Medicaid person to an ADD and then into MLTSS.	8	MR. SPIELBERG: So in appeals there are four
9	And needs are assessed as ar needed to move folks from	9	possible levels. The first two are within the HMO,
10	ADD into MLTSS.	10	then there is an outside review organization, then
11	MS. ORLOWSKI: So it's both, new people to	11	there's and fair hearing. You don't have them broken
12	system and people who	12	down there. That would be very important to break down
13	MR. DUBIN: Yes.	13	because it's not surprising that within the HMO there
14	MS. ORLOWSKI: Because one of the things	14	would be a lot of denials. That's a usual practice.
15	that was discussed leading up to this was whether or	15	But once you get into the other areas, they're usually
16	not there would be so-called woodwork effect. And so	16	more so it would be very helpful to break it down by
17	I'm just curious, what does 4,000 people mean? Does	17	appeal category.
18	that mean there was no woodwork, there was woodwork?	18	MS. ROBENOLT: Right now the way the report
19	How do think about that number?	19	is structured and the way the contract requirement is
20	MS. GRANT: We don't believe that it's	20	is that this is MCO reported data, and it's all
21	woodwork. Remember that the MCO can recommend someone	21	appeals. This is the self-reported appeals here.
22	for assessment, but it really is the State that has to	22	MR. SPIELBERG: So those are only the
23	determine the level of care. So if in fact somebody	23	internal MCO appeals that you're reporting?
24	does not rise to the level of meeting this level of	24	MS. GRANT: It wouldn't include fair
25	care, then they're not eligible. We really refer to it	25	hearings. Not every service gets an IURO. PCA, for
	94		96
1	as growth. When you have a natural aging process, you	1	example, does not.
2	know, people's needs do change as they grow older. And	2	DR. SPITALNIK: What's the acronym?
_	know, people's needs do change as they grow older. And it is something that we monitor.	-	DR. SPITALNIK: What's the acronym? MS. GRANT: Independent Utilization Review
2 3 4	know, people's needs do change as they grow older. And it is something that we monitor. DR. SPITALNIK: Ev Liebman.	2 3 4	DR. SPITALNIK: What's the acronym? MS. GRANT: Independent Utilization Review Organization. It's the Department of Banking and
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	97		99
1	I want to echo some of what Josh said. It	1	look at very closely. So what I'm going to suggest to
2	sold like you get it. We need more transparency. We	2	the MAAC is that the MAAC take on a thorough
3	really need to know what's being asked, what's being	3	examination of that issue over a period of time. Are
4	delivered. Are there then matrix that you're looking	4	we informing in an understandable comprehensible way
5	at?	5	families and consumers at the time of an adverse
6	One thing I want to note is I feel a lot of	6	finding that they have a right to appeal that finding
7	pressure a lot of pressure comes to bear when I'm	7	and what the process for that right is and where there
8	representing clients and we can resolve a matter to	8	is help to file that. I think this is critically
9	withdraw the fair hearing request. I feel very	9	important, and I would urge the MAAC to take that on as
10	uncomfortable about that for lots of different reasons.	10	issue. I would love, by the way, I would absolutely
11	But one is I'm concerned about whether or not it's	11	love to be wrong about this. I would love to be proved
12	being reported. And I think I raise this at the last	12	wrong on this topic. And if a study of it finds me
13	meeting.	13	wrong, I'll be one of the happiest guys on the planet.
14	MS. GRANT: You did.	14	DR. SPITALNIK: Your concerns are noted. We
15	MS. ORLOWSKI: So just thinking forward as	15	need to figure out what the methodology is because we
16	you're collecting information, I would think that it	16	don't take on studies, per se, that the MAAC conducts.
17	should stem to when it's filed, not whether or not it's	17	But whether we can shake the request for information, I
18	actually seen through fruition. Because a lot of these	18	do think there is the issue that people are aware that
19	do resolve informally and we just withdraw you know	19	their funding has changed but not necessarily aware of
20	a common practice is to withdraw the appeal and/or the	20	what their rights are being in a Medicaid program.
21	fair hearing.	21	MS. GRANT: I had one comment really that
22	I also just wanted to briefly note that	22	I'd like to make. It is a requirement that people get
23	there's rumblings coming from our national partners	23	informed. And actually, Medicaid and the Bog Center
24	that the managed care regs are going to come out any	24	worked very close to create a handbook for individuals
25	day now. It might not change it, but it might change	25	with developmental disabilities about how to make
	98		100
1	significantly the appeal process. And so there are	1	managed care work for them. And there is information
2	several of us in the advocacy community who would	2	in there about appeals. And it's my understanding I
3	really like to be able to input in that. And I know we		
		3	mean, we're willing to work with anyone to make sue
4	talked to some of the MCOs and they feel similar. We	4	we're improving that process.
5	can have a good product on the other side. So continue	4 5	we're improving that process. I don't know. And I would like to be able
5 6	can have a good product on the other side. So continue to stand ready when that happens.	4 5 6	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.
5 6 7	can have a good product on the other side. So continue to stand ready when that happens. MS. GRANT: Absolutely.	4 5 6 7	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
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	101		103
1	agenda item. Valerie usually gets to do it. Now it's	1	MS. EDELSTEIN: Just a quick question
2	my turn. So it's just a FamilyCare update on	2	Meghan. I'm just looking at the time frame. The MAAC
3	enrollment. The MAAC asked us to give you updates on	3	meeting is June 15th, which is two weeks before you
4	some topics that they've asked for.	4	have to submit the package.
5	(Presentation by Ms. Davey.)	5	MS. DAVEY: Yes. It's going crunch time.
6	(Slide presentations conducted at Medical	6	But the comments, you'll have it by mid-May. So
7	Assistance Advisory Council meetings are	7	hopefully come prepared with your comments so that we
8	available for viewing at http://www.state.nj.us	8	can vet them. And honestly, once we'll have it, we
9	/humanservices/dmahs/boards/maac/.)	9	have to summarize all the comments for CMS. But during
10	DR. SPITALNIK: I wanted to raise a question	10	that year is a year of negotiating and working through.
11	about the 1115 renewal package. Will there be a	11	So it's not like that's carved in stone on June 1st.
12	synopsis or a summary that indicates the changes and	12	MS. EDELSTEIN: You're going to have a lot
13	the new initiatives that will help people wade through	13	of reading to do that period of time.
14	it?	14	MS. DAVEY: A lot of reading.
15	MS. DAVEY: Yeah, we can to like an	15	DR. SPITALNIK: And in the first
16	executive summary.	16	Comprehensive Waiver, the MAAC served as one of the
17	DR. SPITALNIK: Thank you.	17	major forums for stakeholder input. I don't think that
18	Other questions?	18	as a committee we actually had unified comments, but
19	Beverly.	19	rather provided the forum. And that would be a
20	MS. ROBERTS: So when do you expect that	20	decision to be made going forward.
21	this is going to be available?	21	Others?
22	MS. DAVEY: I would say by mid-May. Right	22 23	Josh and then Paul.
23 24	now it's a lot of information they're requiring for this renewal, just from what we've done over the last	23 24	MS. SPIELBERG: One comment and then one question.
24	four years. So that's in the final stages and then it	24 25	As you were going over the numbers, Meghan,
25		25	As you were going over the numbers, meghan,
1	will go through the Department for sign-off and then it	1	we see that over 400,000 people have been added since
2	will get posted.	2	Medicaid expansion. And I think all of us should take
3	MS. ROBERTS: So will it be sent to the	3	pride in that. I think the MAAC was instrumental in
4	MAAC?	4	convincing the powers-that-be to adopt the Medicaid
5	MS. DAVEY: Phyllis has a Listserv. We said	5	expansion. And I know Valerie and Meghan have been
6	once it's posted, we will send to our Listserv, which	6	instrumental in implementing it. And I think it's
7	includes the MAAC, that it had been posted.	7	important not to take that for granted. These are
8	DR. SPITALNIK: One more question. The	8	people who otherwise wouldn't have had coverage and now
9	evaluation that's being done of the Comprehensive	9	have coverage.
10	Waiver by the Center on State Health Policy, what's the	10	MS. DAVEY: Thank you.
11	timing of those results?	11	MR. SPIELBERG: And now the question. You
12	MS. DAVEY: They require a draft of the	12	said I think there were 60,000 new enrollments in March
4.0	No. DAVET. They require a draft of the	13	and you also said that 12 percent of the people who had
13	interim evaluation as part of the renewal package so	14	
13 14		14	gone on the FFM came back on. When you list new
	interim evaluation as part of the renewal package so	15	gone on the FFM came back on. When you list new enrollments, does it include people who were on before
14	interim evaluation as part of the renewal package so that would be included. And then they have during that		
14 15	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.	15	enrollments, does it include people who were on before
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	105		
1	MR. BLAUSTEIN: Paul Blaustein, NJCDD.		107
2			
	I'm just wondering. The renewal of the Comprehensive Waiver, would that be complicated at all	1	CERTIFICATION
3		3	I, Lisa C. Bradley, the assigned transcriber,
4 5	by the inability to renew the Community Care Waiver?	4	do hereby certify the foregoing transcript of the
	MS. DAVEY: No. Totally separate.	5	proceedings is prepared in full compliance with the
6	MR. BLAUSTEIN: There's no indication of any	6	current Transcript Format for Judicial Proceedings and
7	connection between the two?	7	is a true and accurate compressed transcript of the
8	MS. DAVEY: Unless we want to put the	8	proceedings as recorded.
9	Community Care Waiver into 115, which is a discussion.	10	
10	DR. SPITALNIK: Gwen.	11	Lisa C. Bradley, CCR
11	MS. ORLOWSKI: Gwen Orlowski, Central Jersey	12	The Scribe
12	Legal Services.	13	
13	I want clarity. No concept paper?	14	Date: June 15, 2016
14	MS. DAVEY: So the concepts will be included	15 16	
15	in the full renewal packet.	10	
16	MS. ORLOWSKI: Should we expect it to be the	18	
17	narrative form that the original application was, I	19	
18	think, in September of 2011? Or will we expect it to	20	
19	look more like special terms and condition?	21	
20	MS. DAVEY: It's a combo of both.	22	
21	MS. ORLOWSKI: All right. Thanks.	23	
22	DR. SPITALNIK: One more question.	25	
23	MS. ROBAYO: Linda from Sunovion		
24	Pharmaceuticals.		
25	Can you go back to the Margaret Rose		
	106		
1	information?		
2	MS. DAVEY: Sure. And that will all be		
3	posted.		
4	DR. SPITALNIK: Thank you so much.		
5	So far for our agenda, we have the 115		
6	Waiver and potentially the evaluation report. And I		
7	think we should devote significant time on the agenda		
8	to that; the issues have been raised about DDMI; an		
9	update on the Supports Program which seems it would be		
10	logical in October when there's been more enrollment,		
11	if this is's acceptable to Members; and an update on		
12	credentialing; and the typical on every meeting update		
13	on FamilyCare.		
14	Are there any other agenda items from the		
15	Members?		
16	Do I have a motion for adjournment?		
17	MS. ROBERTS: Motion to adjourn.		
18	MR. WHITMAN: Second.		
19	DR. SPITALNIK: Roberts. Second, Whitman.		
20	And it's 12:59. Have a good spring. Thank		
21	you all for your participation.		
22	(Meeting adjourned 12:59 p.m.)		
23			
24			
<b>25</b>	30 sheets	]	Page 105 to 107 of 107