MEDICAL ASSISTANCE ADVISORY COUNCIL MEETING

New Jersey State Police Headquarters Complex
Public Health, Environmental and Agricultural
Laboratory Building
3 Schwarzkopf Drive
Ewing Township, New Jersey 08628

June 15, 2015
10:16 a.m.

FINAL

MEETING SUMMARY

MEMBERS PRESENT:
- Deborah Spitalnik, PhD, Chair
- Sherl Brand
- Mary Coogan
- Theresa Edlestein
- Dennis Lafer
- Beverly Roberts
- Sidney Whitman, DDS

MEMBERS EXCUSED:
- Dot Libman
- Mary Lund
- Jay Jimenez
- Wayne Vivian

MEMBERS UNEXCUSED:
- Eileen Coyne

STATE REPRESENTATIVE:
Valerie Harr, Director
Division of Medical Assistance and Health Services

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

ATTENDEES:

Evelyn Liebman	AARP
Lynn Haynes	Advocacy & Management Group
Chelsea-Lee Hanks	Archer Law Office, LLC
Matt Minnella	Association of New Jersey Chiropractors
Linda Posta	Astellas Pharma U.S., Inc.
Nina Greier	Bancroft Neuro Rehab
Dean Roth	Burlin Consulting
Gwen Orlowski	Central Jersey Legal Services
Angela Mathis-Rhodes	Burlington County Board of Social Services
Shabnam Salih	Camden Coalition of Health Care Providers
Mary-Catherine Bohan	Community Care Behavioral Health Organization
Greg Papazian	Consultant
Virginia Plaza	Consultant
Susan Saidel	Disability Rights New Jersey
Gwen Cleary	Eli Lilly and Company
Chrissy Buteas	Home Care Association of New Jersey
Geralynn Boone	Horizon NJ Health
Joseph Manger	Horizon NJ Health
Cynthia Roberts	IntelliRide
Joshua Spielberg	Legal Services of New Jersey
Barbara Dunn	Magellan Health Care
Elizabeth Andolino	Matheny Center of Medicine and Dentistry
Rebecca Esmi	McNeely, McGuigan & Esmi, LLC
Melinda Martinson	Medical Society of New Jersey
Walter Lewis	Moss Rehab Einstein Healthcare Network
Mary Abrams	NJ Association of Mental Health and Addiction Agencies
S. Lubitz	NJ Association of Mental Health and Addiction Agencies
Stephanie Pratico	NJ Council on Developmental Disabilities
Kevin Casey	NJ Council on Developmental Disabilities
Brian Francz	NJ Department of the Treasury
Desmond Webb	NJ Department of the Treasury
Kate Clark	New Jersey Family Planning League
Anh Pham	New Jersey Health Care Quality Institute
James McCracken	NJ Office of the Ombudsman for the Institutional Elderly

Elissa Smith	NJ Office of the State Comptroller/Medicaid Fraud Division
Phillip Lubitz	NAMI of New Jersey
Karen Shablin	Optum
Matt D'Oria	PerformCare of New Jersey
Rebecca Barsom	Planned Parenthood of Central Greater Northern New Jersey
Mary Kay Roberts	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Kathleen Lockbaum	Salem County Welfare Agency
Vincent C. Ceglia	UnitedHealthcare
Zinke McGeady	Values Into Action NJ
John Kirchner	WellCare
Lisa Knowles	WellCare
Nancy Day	NJ Division of Aging Services
Karen Kasick	NJ Division of Family Development
Dawn Apgar	NJ Department of Human Services
Lowell Arye	NJ Department of Human Services
Roxanne Kennedy	NJ Division of Medical Assistance & Health Services
Thomas Lind	NJ Division of Medical Assistance & Health Services
Phyllis Melendez	NJ Division of Medical Assistance & Health Services

1 DR. SPITALNIK: Good morning. We'll
2 officially start the Medical Assistance Advisory
3 Council (MAAC) meeting. I'm Deborah Spitalnik, the
4 Chair. And the first thing that I will start with is
5 the required Open Public Meetings notice, that pursuant
6 to New Jersey's Open Public Meetings Act, adequate
7 notice of scheduled quarterly meetings for the calendar
8 year of 2015 of the Medical Assistance Advisory Council
9 was issued by the NJ Department of Human Services
10 (DHS).
11 We have complied with all the filings. I
12 will give it to Ms. Bradley to include.
13 (See attachment.)
14 Because we are guests here at the Public
15 Health Lab of the State Police, I need to also notify
16 you that I need to read the public emergency evacuation
17 procedure, that if the fire alarm or evacuation
18 announcement came over the public address system, you
19 need to quickly leave the building by the nearest exit,
20 go to Lamp Post No. 9 in the parking lot. Once there,
21 you will report to Valerie Harr or Phyllis Melendez who
22 will check your names off the attendance sheet, and we
23 will wait in that designated area for instructions from
24 emergency response personnel. Thank you.
25 For those of you who are new attendees, and

1 reminders to old ones, what we will do is I will ask
2 the members the MAAC to introduce themselves. I will
3 ask the members of the public to introduce themselves.
4 That's not a period for public comment or questions.
5 We have been very fortunate in terms of the
6 collaboration between the MAAC and stakeholders that we
7 do not have an isolated period for public comment, but
8 rather around each subject area, we welcome questions
9 and discussion. But our ground rules are that the MAAC
10 members get to ask questions or make comments first
11 before I open it to the floor. We reserve the right to
12 have to structure that differently, but I appreciate
13 everyone's cooperation. And I think it's made for a
14 very rich dialog, even amongst such a large group of
15 stakeholders. And we're always gratified to see people
16 here.
17 Our agenda today first starts with the
18 approval of minutes and then a series of informational
19 updates. So with that, I will ask the members of the
20 MAAC to introduce themselves.
21 (MAAC members introduce themselves.)
22 (Members of the public introduce
23 themselves.)
24 DR. SPITALNIK: Thank you. And again,
25 welcome to everyone.

1 Our next item of business is approval of
2 minutes. We have two sets of minutes. We have the
3 final summary from October 6th.
4 Any comments or corrections?
5 MS. ROBERTS: On October?
6 DR. SPITALNIK: Yes.
7 MS. ROBERTS: No.
8 DR. SPITALNIK: Hearing none, do I have a
9 motion for approval?
10 MS. BRAND: So moved.
11 MS. COOGAN: Second.
12 DR. SPITALNIK: Brand; and second, Coogan.
13 All those in favor?
14 MAAC MEMBERS: Aye.
15 DR. SPITALNIK: The October 6th minutes are
16 accepted.
17 We now turn to the April 13th minutes which
18 are a draft. Any comments or suggestions?
19 Bev Roberts.
20 MS. ROBERTS: I have a question and a
21 comment. I marked a couple of small little typos, and
22 I can give them to Phyllis. It's nothing substantive.
23 But my more substantive question has to do with when
24 the presentations have been made, the transcription
25 says this person made a presentation, and then it goes

1 on to whatever questions and answers there were after
2 that.
3 DR. SPITALNIK: Right.
4 MS. ROBERTS: So I'm wondering -- and I know
5 that the slides are on the website, but if somebody
6 didn't know that and was just looking at the minutes,
7 they don't have a full recording of what happened
8 because all of the slides are not there. So I don't
9 know if there's some way to reference that, because
10 otherwise you don't have it.
11 DR. SPITALNIK: Well, procedurally, it is on
12 the cover of each summary, but I would be happy repeat
13 that at the introduction of the speaker just as a
14 matter of process, if that would be helpful to people.
15 Slide prsentations are available at:
16 http://www.stat.nj.us/humanservices/dmahs/boards/maac
17 And again, we used to be able to print
18 pretty much unlimited copies of the slides for the
19 members of the public, but that is not environmentally
20 friendly. So the members of the MAAC and the public
21 receive those electronically. When someone uses a
22 PowerPoint, it will be up here and then they're posted
23 on the MAAC website shortly after the meeting.
24 So thank you for that. I think that's not a
25 correction in the minutes, but I would certainly add

1 that to our process.
2 And so we have some typos that you would
3 give to Lisa or to Phyllis. Are they of such
4 significance that we could not act on the minutes?
5 MS. ROBERTS: Not at all.
6 DR. SPITALNIK: So I need a motion for the
7 approval of the minutes of April 13th.
8 MS. BRAND: I'll motion to approve.
9 MS. COOGAN: Second.
10 DR. SPITALNIK: Brand; second, Coogan.
11 All those in favor?
12 MAAC MEMBERS: Ayes.
13 DR. SPITALNIK: Opposed?
14 Abstentions?
15 The minutes of April 13th are accepted, with
16 minor corrections.
17 In terms of the efficacy of the minutes,
18 Lisa can see our names up here, but if you are speaking
19 from the floor, we ask that you identify yourself by
20 name so the minutes can reflect that.
21 So we will now move on to the substantive
22 part of our business, which are a series of significant
23 informational updates. And it's my pleasure to
24 introduce Roxanne Kennedy, who is Director of Managed
25 Behavioral Health in the Division of Medical Assistance

1 and Health Services. And as noted previously, the
2 slides will be on the MAAC website.
3 Roxanne.
4 MS. KENNEDY: Thank you. I'm here to
5 introduce the Interim Managing Entity (IME), as well as
6 to give you some updates of behavioral health under New
7 Jersey Medicaid.
8 If you remember, in the Comprehensive
9 Medicaid Waiver (CMW), we got approved in 2012, these
10 were some of the highlights for Behavioral Health.
11 (Presentation by Ms. Kennedy.)
12 (Slide presentations are available for
13 viewing at: Http://www.state.nj.us/
14 humanservices/dmahs/boards/maac/)
15 DR. SPITALNIK: Thank you so much.
16 Are there questions?
17 Mary.
18 MS. COOGAN: Does the individual have to
19 call this number, or could an agency or social worker
20 working with an individual make a referral?
21 MS. KENNEDY: Both could. An individual
22 could call or a provider could have an individual walk
23 into their office and the provider can call for them,
24 as well.
25 MS. COOGAN: But the individual has to be

1 there?
2 MS. KENNEDY: Correct.
3 DR. SPITALNIK: Bev.
4 MS. ROBERTS: Thanks, Roxanne.
5 I'd like it to be noted that currently
6 individuals who have intellectual and developmental
7 disabilities and also have a behavioral health problem
8 are supposed to receive their behavioral health
9 services from the Medicaid MCO, different from
10 everybody else. That was a decision that was made a
11 long time ago. And also, going back a couple years
12 ago, a work group had been convened specifically to
13 look at in whatever the future system is that there be
14 a particular emphasis on improving the level of service
15 and the rates for providers, behavioral health
16 providers, providing services to individuals who have
17 intellectual and developmental disabilities. So I just
18 want that to be noted so that as this moves forward,
19 the work and the input that had been given are
20 incorporated into whatever it is that comes next.
21 DR. SPITALNIK: Bev, thanks, but I would add
22 a modifier to what you said. It's individuals who are
23 clients of the Division of Developmental Disabilities
24 whose behavioral health services are carved into the
25 MCO, not people who might bear that diagnosis but are

1 not clients of DDD.
2 MS. ROBERTS: Correct.
3 DR. SPITALNIK: So it's more specific.
4 Did you want to modify that at all?
5 MS. HARR: I thought you were going to say
6 also now with Managed Long Term Services and Supports
7 (MLTSS), anyone enrolled in MLTSS Behavioral Health is
8 the responsibility of the health plan.
9 So I believe, Roxanne, you can correct me if
10 I'm wrong, but should someone call the hotline in need
11 of substance use disorder services, the IME will be
12 checking for Medicaid NJ FamilyCare eligibility and
13 would be coordinating or referring the client to the
14 managed care program if that service is carved in.
15 MS. KENNEDY: Correct.
16 DR. SPITALNIK: So substance abuse is carved
17 into the MCO for MLTSS.
18 MS. KENNEDY: Yes. The methadone
19 maintenance service only is carved into MLTSS because
20 it's in the State plan, not the new ABP expansion
21 population services we have. Methadone maintenance is
22 the only substance use disorder benefit within the
23 MLTSS.
24 DR. SPITALNIK: Thank you.
25 Any other questions?

12

1 MR. LAFER: Since we've working with the ASO
2 for about four years, I was wondering since it's no
3 longer viable, what were the issues why it was pulled
4 out?
5 MS. HARR: I think there were a number of
6 things that sort of changed over time from when it was
7 originally conceptionalized and the RFP put together.
8 One is we learned with MLTSS the startup of one of
9 these major changes is significant. So there's concern
10 around the ASO and the startup and really what is the
11 return on investment with that type of model. And the
12 second is now that we have carved Behavioral Health
13 into MLTSS and all of us have learned so much from that
14 experience that I think, again, so much has changed and
15 so much progress has been made that collectively
16 between Division of Mental Health and Addictions and
17 Medicaid agency, we are rethinking the best way to
18 really have the integrated care. And thinking that
19 maybe going to the full risk -- there are lots of pros
20 to that -- or carving it in -- there are a lot of
21 advantages to that -- and have been pleasantly
22 surprised at how well Behavioral Health is being
23 handled under MLTSS.
24 MR. LAFER: So the options that are on the
25 bottom of that page that Roxanne just went over, those

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1 are the only two options that are being considered, or
2 there other options on the table? The separate MBHO or
3 when it's carved into the current HMOs? Other states
4 have kind of moved into other directions. So are there
5 other considerations for New Jersey?
6 MS. HARR: I think those are the two
7 considerations.
8 DR. SPITALNIK: Anyone else from the MAAC?
9 I would open it up to the public.
10 MR. LUBITZ: Phil Lubitz from NAMI of New
11 Jersey.
12 During the Administrative Services
13 Organization (ASO) project there was a -- I think we
14 called it a "cloak of silence" that was put on it, but
15 that had to do with the procurement process and
16 Treasury. Since that's no longer on the table, at this
17 point is the "cloak of silence" gone? And are we then
18 going to reconvene the stakeholders, since we're really
19 talking about changing directions? One concern is
20 stakeholders put a lot of input into various
21 subcommittees that talked about the clinical aspects,
22 the financial aspects, and outcomes. Is that going to
23 be incorporated? And to what extent then are we going
24 reconvene stakeholders to be part of this process as we
25 consider the various options.

14

1 MS. HARR: We will be reconvening the
2 steering committee. I think the next step is with the
3 Myers & Stauffer rates. We've been talking and there
4 was a fiscal subcommittee, and that would be the group
5 we would bring together first. Yes, we will bring the
6 steering committee together, but right now I think
7 there's emphasis is on getting the IME up and running.
8 So we haven't focused on and don't have a time frame.
9 We're really just starting to talk internally about
10 what's next, instead of the ASO. But, yes, we will use
11 the Steering Committee to help guide the State.
12 MS. KENNEDY: Just to add to that, we're
13 doing a deep dive in data analysis and also
14 utilization, given the fact that we now have the
15 Alternative Benefits Plan (ABP) since we had originally
16 proposed an ASO. So we want to reevaluate where we are
17 today, do the utilization data, do a fiscal analysis,
18 what is it we're looking at, what's the administrative
19 cost. We're doing a very deep dive into that. That,
20 along with the Myers & Stauffer rate, and the potential
21 of equalizing the ABP benefit to the State Plan A
22 benefit are all part of our consideration of what
23 happens next. And I agree, we will convene the
24 Steering Committee at some later point. I think
25 initially it will be the fiscal work group to go over

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1 the new Myers & Stauffer rates.
2 DR. SPITALNIK: Phil, did you want to
3 follow-up?
4 MR. LUBITZ: Just one follow-up. Since I'm
5 hearing that there's going to be sort of a reuse of
6 mental health block grant funds, I'd suggest that
7 someone come to the Behavior Health Planning Council to
8 talk about this, because that Council is going to be
9 commenting. And I think the federal requirement is
10 that they have an opportunity to review a plan. That
11 plan gets submitted September 1. So I think there are
12 two meetings that you would have an opportunity to come
13 and present that to the Council.
14 MS. HARR: Are you talking about the IME or
15 the --
16 MR. LUBITZ: I heard that mental health
17 block grant funds are going to be placed into the IME.
18 And that will be a part of the next block, so I think
19 the Council is going to have to have an opportunity, at
20 minimum, to review that.
21 MS. KENNEDY: I can talk to Lynn Kovich
22 about that.
23 DR. SPITALNIK: Thank you.
24 Anyone else?
25 Roxanne, thank you so much.

16

1 We now move to the issue of provider
2 credentialing with an update from Dr. Thomas Lind,
3 who's the Medical Director of the Division of Medical
4 Assistance and Health Services.
5 Dr. Lind.
6 DR. LIND: Good morning. I would like to
7 provide you with an update of the relatively brief
8 period of time that's past since our last meeting and
9 the progress that we've made with implementation of the
10 recommendations of the task force.
11 On May 1st, I believe the Medicaid solutions
12 was over at the replacement MMIS contract and
13 post-award Digital Harbor was selected as the
14 subcontractor that will handle the credentialing
15 function management. And we're currently working with
16 them to design and development and process and project
17 roadmap and to come up with clear objectives and
18 milestones. And we are currently on time for our
19 June 30, 2016 projected start.
20 And that is where we are currently.
21 DR. SPITALNIK: Thank you so much.
22 Questions or comments from the MAAC?
23 DR. WHITMAN: Where does that put
24 third-party administrators in this thing with
25 credentialing?

17

1 DR. LIND: This is a third-party
2 administrator Digital Harbor is the third-party that
3 will be managing.
4 DR. WHITMAN: I just want to understand so I
5 can report back. And they will be taking care of all
6 of the different MCOs?
7 DR. LIND: That is correct, and fee for
8 service, but only for the medical, dental, and
9 behavioral health providers.
10 DR. WHITMAN: Okay. Thank you.
11 DR. SPITALNIK: Thank you.
12 Anyone from the public, any questions about
13 credentialing?
14 Thank you. And congratulations on it moving
15 ahead so firmly.
16 I now turn to Director Valerie Harr for an
17 update on New Jersey FamilyCare expansion enrollment.
18 MS. HARR: So I'll give the latest
19 enrollment numbers since we last met. We now enroll
20 over 476,000 individuals, including both the expansion
21 population and then what we call "woodwork." Those are
22 individuals that had been previously eligible for
23 enrollment in one of our Medicaid or NJ FamilyCare
24 programs that had not enrolled. I think the majority
25 of those individuals are children, so that's really

18

1 great that we're reaching and enrolling a lot of the
2 children that had, again, been previously eligible, for
3 whatever reason had not enrolled.
4 (Presentation by MS. Harr.)
5 (Slide presentations are available for
6 viewing at: Http://www.state.nj.us/
7 humanservices/dmahs/boards/maac/)
8 DR. SPITALNIK: Before you go to the
9 Accountable Care Organization (ACO), given that there's
10 so much information, let's look at whether there are
11 any questions about the NJ FamilyCare expansion and
12 enrollment from the MAAC.
13 Mary.
14 MS. COOGAN: First of all, I want to say
15 congratulations. These numbers are tremendous.
16 In terms of the backlog that's been
17 discussed at prior meetings, a lot, I understand, was
18 shifted to the State vendor to take care of some of
19 that.
20 MS. HARR: Yes.
21 MS. COOGAN: So the data that you showed us
22 today reflects that shift? Is there still --
23 MS. HARR: Yes. And I didn't bring those
24 numbers with me, but all of the backlog for all of the
25 applications that were filed online at njfamilycare.org

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1 have all been moved to the health benefits coordinator
2 and processed. We have asked the county welfare
3 agencies to report to us any backlog they may have with
4 paper applications. I think it's minimal in that
5 respect. We did have one county drive their paper
6 applications to the health benefits coordinator for the
7 health benefits coordinator to assist them. But I
8 think other than that, the paper backlog is, again,
9 minimal. So the backlog in general has been cleaned
10 up. Online applications have been redirected to the
11 health benefits coordinator with the exception of, I
12 think it's three counties that previously demonstrated
13 they did not have a backlog, so they continue to get
14 the online applications.
15 Again, we continue to work with the county
16 welfare agencies, encouraging and having them focus on
17 redeterminations. And we have over 100,000 individuals
18 that originally applied and got eligibility through the
19 Marketplace for NJ FamilyCare that need a
20 redetermination completed. And the health benefits
21 coordinator is handling those redeterminations
22 regardless of the county that the person resides. They
23 started to send the first batch of redeterminations for
24 Marketplace cases in May. We're expecting all of those
25 100-plus thousand redeterminations to have been touched

20

1 in terms of a letter being sent and an application
2 being sent, by the end of July.
3 MS. COOGAN: Terrific. Thank you.
4 DR. SPITALNIK: Dennis.
5 MR. LAFER: I think you showed 40 percent
6 increase in enrollment. What percentage increase in
7 cost did you experience for those people, as well?
8 MS. HARR: For the expansion?
9 MR. LAFER: Right. You said the Expansion,
10 40 percent enrollment which is 40 percent of the total
11 population. I was just wondering what is the
12 relationship between that and the cost associated
13 within that total.
14 MS. HARR: I don't know. I'll have to get
15 back to you. The only thing I have here in the
16 presentation are actuals. That's the actuals. I don't
17 know what the percent increase is. I'm going to take a
18 wild leap, the per member per month (PMPM) for the
19 Expansion population is more than a child PMPM,
20 definitely less than a dual eligible or someone in
21 Managed Long Term Services and Supports (MLTSS).
22 MS. LAFER: At 1.3 billion, you said. What
23 is that?
24 MS. HARR: Well, I mean, the total Medicaid
25 budget now is $12 billion.

21

1 MR. LAFER: So it's approximately
2 12 percent, so it grew by 40 percent and the Expansion
3 by 12 percent?
4 MS. HARR: I'll take your word for it.
5 MR. LAFER: Something like that.
6 DR. SPITALNIK: Thank you.
7 Other questions?
8 Hearing none from the MAAC, are there
9 questions from the audience about the NJ FamilyCare
10 Expansion enrollment?
11 Gwen. And then Josh.
12 MS. ORLOWSKI: Hello, I'm Gwen Orlowski,
13 currently from Central Jersey Legal Services. Again,
14 thank you for all this. The numbers are wonderful.
15 I have a question about these
16 redeterminations that are going to be done for people
17 who came through the Marketplace originally. Some
18 percentage of those are going to be Expansion Medicaid
19 folk, and some of those folks are going to have turned
20 65 or have gotten their Medicare through disability
21 determinations since they first came in. And I'm just
22 wondering what systems are in place to make sure that
23 those people are screened for other Medicaid
24 eligibility?
25 MS. HARR: I can get back to you with more

22

1 detail on the actual process and requirements. But,
2 yes, so they would have all started out with Expansion,
3 the adult expansion population. For any number of
4 reasons, they may lose eligibility or now qualify for
5 another program. And so the health benefits
6 coordinator would need to also screen for other
7 programs and make a referral to the county welfare
8 agency if it's a non-MAGI-based eligibility
9 determination that needs to be made. But I'll check
10 with my operations folks to make sure I know exactly
11 how that hand-off would occur.
12 MS. ORLOWSKI: I just have a quick follow-up
13 on that.
14 So those folks would not be terminated
15 pending that redetermination or that non-MAGI
16 determination screening at the county level? Is that
17 what we should expect?
18 The concern I have is some of those people
19 may be inappropriately terminated without that full
20 screen based on disability.
21 MS. HARR: I will to check to see how that
22 will work. Ultimately, we would want it to be
23 occurring in real time so that someone can be -- if
24 they're found ineligible for a MAGI program, they could
25 be immediately reviewed for another program so there's

23

1 no gap in coverage. I'll have to see how seamlessly
2 that occurs, or will occur.
3 DR. SPITALNIK: Thank you.
4 Josh.
5 MR. SPIELBERG: Josh Spielberg, Legal
6 Services of New Jersey.
7 Valerie, you had a slide up which showed the
8 percentage of applications processed in 45 days.
9 MS. HARR: Right.
10 MR. SPIELBERG: So it looks like the high
11 point was in December of 2014 where 95 percent. And
12 then it's gone down most other months. It's now at
13 75 percent. Do you know the reason that it's going
14 back down instead of staying up at that higher level?
15 MS. HARR: I'll confirm this, but I think
16 it's based on volume and probably taking on the backlog
17 applications. I think it's also that period when it
18 was open enrollment on the Marketplace, so my sense is
19 it's based on volume. It could also just be more of
20 the complexity of the cases. I'll have to confirm.
21 MR. SPIELBERG: Thank you.
22 DR. SPITALNIK: Thank you.
23 Ev.
24 MS. LIEBMAN: Hi. Evelyn Liebman, with
25 AARP. Just a follow-up with Josh's question on this

1 slide.
2 At this point, what is the percentage of
3 applications being processed by Xerox versus the county
4 welfare agencies?
5 And two, beyond 45 days, just some sense of
6 the 25 percent of the applications that are above
7 45 days old, are we looking at 60 days, 90 days? And
8 what might be the reasoning for that?
9 MS. HARR: I'll have to look into the reason
10 and find out what percent. I'm accustomed to the
11 applications at the health benefits coordinator, in
12 most cases, being processes within two weeks. So I'll
13 see what's behind these numbers.
14 What was the first part of your question?
15 MS. LIEBMAN: The percentage of applications
16 that you process by the HBC versus the county agencies?
17 MS. HARR: Again, I don't have that off the
18 top of my head. If we take a snapshot in time with
19 backlog, it would be a higher percentage. But the
20 county agencies are still processing the majority of
21 applications.
22 DR. SPITALNIK: Anyone else?
23 Were there any questions on the
24 transportation update?
25 If not, Valerie, we'll turn to you again for

1 the accountable care organizations update.
2 MS. HARR: Thanks. Just to remind everyone
3 that originally we had eight organizations apply to be
4 certified as Medicaid accountable care organizations in
5 accordance with the statute that was passed. Two
6 withdrew their applications, so the remaining
7 applicants are Camden Coalition of Healthcare
8 Providers, the Trenton Health Team, Healthy Greater
9 Newark, New Brunswick Health Partners, Passaic County,
10 and Healthy Cumberland.
11 We're in the final stages of review. We did
12 an original review. We sent requests for additional
13 information to the applicants who returned the
14 information. Again, in the final stages of review, I'm
15 essentially wrapping that up, drafting letters to the
16 applicants and providing a summary to move up through
17 the Commissioner, the Governor's Office, so they are
18 aware and approve prior to us making any announcement.
19 But I do expect an announcement to be made very soon.
20 We had been targeting a July 1st effective date. I
21 don't think that's realistic at this point, but we're
22 very close. So, again, progress; that's some great
23 news.
24 DR. SPITALNIK: Thank you. Any questions
25 about the ACOs from the MAAC?

1 Any questions from stakeholders?
2 Thank you so much. And these slides will be
3 on the website.
4 I'm pleased to turn to Lowell Arye, Deputy
5 Commissioner of DHS, for an update on Managed Long Term
6 Services and Supports, as we approach his first
7 anniversary.
8 MR. ARYE: Yes, we are now toddling along
9 with MLTSS.
10 Before I go any further, let me first say
11 that I'm supposed to be wearing purple today. If you
12 notice, our division director, Nancy Day for the
13 Division of Aging Services is wearing purple. Today is
14 World Elder Justice Day, and the Division of Aging
15 Services, ABS, is working with a number of folks and
16 partnering on that, so I just wanted to kind of
17 announce it. It has been a very important piece and a
18 lot of people have been really focused on this side.
19 So I really just kind of wanted to acknowledge and
20 remind everybody that seniors do get exploited, abused,
21 neglected, both by individuals outside of their family,
22 but also by individuals inside of their family. We
23 really need to focus on that, so just kind of FYI.
24 Second of all, in about 16 days from today,
25 we will be year one into MLTSS, and so I'm really

1 excited and pleased about that. I've been telling
2 people at our National Association of States United for
3 Aging and Disability that we are moving forward. So
4 we're very exited about that.
5 Today, I'm going to continue with our usual
6 dashboard indicators. The MAAC had actually asked for
7 appeals, grievances, and complaints, so we're going
8 talk about that, as well as a bit of a provider update.
9 (Presentation by Mr. Arye.)
10 (Slide presentations are available for
11 viewing at: Http://www.state.nj.us/
12 humanservices/dmahs/boards/maac/)
13 DR. SPITALNIK: Lowell, if you're about to
14 move to appeals, what I would ask is that we stop here
15 and take questions related to the data that you just
16 presented. And thank you so much for it.
17 Beverly.
18 MS. ROBERTS: Thanks very much, Lowell, for
19 all this information.
20 I have a question about the slide with the
21 pie chart where it gave the percentage 0 to 64. As you
22 know, the group that I am most interested in are the
23 folks that were in the Medicaid waiver populations that
24 were transitioned into MLTSS, the younger people,
25 primarily younger. And I'm assuming that in that in

1 that 0 to 64.
2 MR. ARYE: That's exactly right. And
3 unfortunately, we haven't been able to fully break out
4 the demographics by specific age. We're trying to get
5 there. And I think that over the next few orders,
6 you're going to see more and more of that. We're
7 trying our best to kind of glean from that data and
8 that information.
9 MS. ROBERTS: That would be terrific.
10 MR. ARYE: We are trying our best. And
11 you'll see when we get to grievances and appeals that
12 we've started to do that in the grievance and appeals.
13 So we're trying to deal with those specifics. We're,
14 of course, interested in knowing this population as
15 well.
16 MS. ROBERTS: Thank you.
17 DR. SPITALNIK: Other questions?
18 Dennis.
19 MR. LAFER: Since this is the first time
20 Behavioral Health is being managed, I'm wondering if
21 you are looking specifically on what's going in the
22 mental health component of MLTSS, particularly the
23 diagnosis, age.
24 MR. ARYE: We haven't quite gleaned that out
25 yet. Certainly, the majority of folks who are at

1 Behavorial Health, we're going to see a lot of TDI
2 because of their behavorial issues, as well as the
3 seniors who are in depression and all of that. Our
4 next hit with the demographics is to start to go
5 through that and start to glean that stuff out.
6 I think what we are hearing anecdotally is
7 that a lot of our success stories from the MCOs has
8 been specifically on how they have been integrating the
9 behavioral component into this, but we haven't quite
10 gotten into the specific data points on that. So we
11 will be doing that. Certainly, I'm just as interested
12 as you to see that, actually.
13 MS. HARR: I think each week on our calls
14 with the health plans each week, the plans report to
15 us. They know their members that are getting
16 behavioral health services through MLTSS and they're
17 reporting to us the number of members, but we haven't
18 the dove into the data yet. So we have a lot of data
19 wish lists.
20 DR. SPITALNIK: Thank you.
21 Anyone else?
22 Gwen.
23 MS. ORLOWSKI: Hi. Gwen Orlowski again,
24 Central Jersey Legal Services. Thank you so much,
25 Lowell.

1 One of your earlier slides gave a figure of
2 32.5 percent as Home and Community-Based Services
3 (HCBS). Can you tell us exactly what's in that
4 32.5 percent?
5 I'll explain what I mean. Does that
6 include, for example, state plans PCA, state plan adult
7 health? Or is it just people in MLTSS who are getting
8 HCBS? And does it include the CCW waiver?
9 MR. ARYE: No, it does not include the CCW
10 waiver. If I remember correctly, it does not include
11 medical day or PCA. We as a state do look at PCA,
12 medical day as a home community base services. And
13 actually, when we look at the BIP, the Balancing
14 Incentive Payment Program, and work with CMS on that
15 and we report to them, we do include it. But on this
16 it is just what you used to be just long-term care
17 side. So even on medical day and the PCA services does
18 support people who are in the community who have
19 long-term care needs, it's not that part.
20 MS. ORLOWSKI: Thank you.
21 DR. SPITALNIK: Other questions or comments?
22 Thank you.
23 Lowell, let's go okay to your next chunk of
24 presentation.
25 MR. ARYE: Basically, what I want to say is

1 that we've been requiring data from the NCOs on
2 grievances, appeals, and the like. Specifically, the
3 contract specifically requires the MCOs to report on a
4 quarterly basis to Medicaid the member and provider
5 complaints, grievances, and appeals, resolutions,
6 timeliness, et cetera.
7 (Presentation by Mr. Arye.)
8 (Slide presentations are available for
9 viewing at: Http://www.state.nj.us/
10 humanservices/dmahs/boards/maac/)
11 DR. SPITALNIK: Thank you. Any questions?
12 Sherl.
13 MS. BRAND: Lowell, thank you very much for
14 the report.
15 For the denials, is there anything that you
16 can add with respect to what the majority involved?
17 Was it medical necessity, or was it some other category
18 for denial?
19 MR. ARYE: I don't have that. I'm sorry.
20 I'll get it for you.
21 MS. BRAND: Okay, great. Thank you.
22 DR. SPITALNIK: Bev.
23 MS. ROBERTS: Thanks, Lowell. This is
24 really great information. I just have few questions.
25 There's a lot of data here.

32

1 Going back to Slide No. 39, the appeals
2 categories reported -- this is just assumption. My
3 assumption is that the PDN both in the 0 to 20 and 21
4 to 64, that there's a good chance that those were CRPD
5 level approval?
6 MR. ARYE: Yes.
7 MS. ROBERTS: So even looking at 21 to 64,
8 you could have people early onset Alzheimer's or
9 whatever who are not necessarily the PDN, but are in
10 that category with other kinds of problems different
11 from the types of problems that you and I talk about,
12 which are the PDN issues.
13 MR. ARYE: You could. But as you can see,
14 only 12 grievances out of however many people are
15 receiving are PDN, that's a very small number. So
16 you're right, it could be some people with early onset
17 Alzheimer's who might have it, but I'm assuming -- and
18 as I said, we haven't teased all of this out yet and
19 can't do it by diagnosis, per se, so we're trying to
20 figure out how to tease it out otherwise. I'm assuming
21 the majority of those folks are the folks who were the
22 former CRPD folks.
23 MS. ROBERTS: A question about appeal
24 resolutions, that terminology. People have Stage 1,
25 Stage 2, Stage 3 Medicaid fair hearing, and they can do

33

1 part or all of those. Do you know if these were
2 people, looking across the board, who did go to a
3 Medicaid fair hearing or if it were not, is that
4 information as well?
5 MR. ARYE: Carol.
6 MS. GRANT: I don't know that we have that
7 data. We do know that people, because they can do
8 several different things, go to fair hearing, file both
9 concurrently, or go to fair hearing afterward. It's
10 very hard to tease that out.
11 MS. HARR: This data is from the plans.
12 MS. GRANT: It's from the plan reported
13 complaints. It wouldn't include fair hearing. But it
14 could be the DOBI third level of appeal except for PCA.
15 MS. ROBERTS: So there's additional data if
16 something went to a Medicaid fair hearing for any of
17 these categories that's not included?
18 MR. ARYE: Correct.
19 MS. GRANT: It would be reported separately.
20 MS. ROBERTS: If we're going forward, that
21 would be really good to know.
22 MS. GRANT: I think there's some difficulty
23 because we've tried to do this before. Fair hearings
24 get scheduled, they get unscheduled, so it's not
25 something that happens as regularly as this would.

34

1 MS. ROBERTS: But if at some point if that
2 could be gathered in whatever way, that might be really
3 helpful information.
4 Could you just talk briefly what the
5 exceptions is? Talk about that a little bit. That
6 will be helpful.
7 MS. GRANT: Well, the exception process was
8 really designed to look at individuals who were
9 originally hitting what was a cost cap. It was really
10 designed to look at medical necessity so that we were
11 not really disenfranchising individuals who really have
12 a very extreme level of need. And it's signed off by
13 the health plan, signed off by the Medicaid medical
14 director. And it really took, I think, a lot of sort
15 of what had been sort of the basis for an appeal on
16 PDN. We took a look at our own regulations and we
17 submitted a proposed exception process to CMS and it
18 was approved. And it appears basically from what we
19 know and what we've heard that it's working.
20 DR. SPITALNIK: Thank you.
21 MS. ROBERTS: Thank you.
22 My understanding is these were folks -- it
23 wasn't that they didn't have medical necessity for PDN,
24 but the problem was that they were hitting the cost
25 cap.

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1 MR. ARYE: That's correct.
2 MS. GRANT: That's exactly right.
3 DR. SPITALNIK: Anyone else?
4 Anyone in the audience with questions?
5 Josh.
6 MR. SPIELBERG: Josh Spielberg, Legal
7 Services of New Jersey.
8 So I think it would be helpful to have more
9 appeal data so that it would be useful to see almost
10 like the moderation data that you have for what
11 category people were in, to just see when there was a
12 determination of -- usually a reduction in hours, I
13 think, is what you would see. How many of those are
14 appealed, how many are resolved at Level 1, Level 2,
15 Level 3, when that happens and then a fair hearing just
16 to see what percentage of those cases are being
17 appealed and how they're resolved. So if you can
18 develop that data, I think it would be helpful.
19 MR. ARYE: I would concur with you. And as
20 I said, this is our first cut at this literally because
21 we did have trouble with that first set of data. So
22 now that we're moving forward, Maribeth really got
23 pushed by me to get me some data, and we wanted it to
24 be clean. So I think that as we move forward, we'll
25 cleaner and we'll be able to kind of break it out a

36

1 little bit more.
2 MS. GRANT: I want to point out that we
3 don't get Independent Untilization Review Organization
4 (IURO) or the third level of NJ Department of Banking
5 and Insurance (DOBI) appeal information a reported to
6 us. There's a confidentiality factor that's involved
7 there, so that's something we would have to actually
8 ask the plans for. They're probably notified.
9 DR. SPITALNIK: Could you spell out that
10 acronym?
11 MS. GRANT: Independent Utilization Review
12 Organization.
13 DR. SPITALNIK: Thank you.
14 MS. GRANT: It's really peer review. It
15 looks at medical necessity. It does not look at PCA.
16 PCA is not determined to have a medical necessity
17 standard, even though our regulations do require a
18 certain sign-off by a PCP. The thing is the fair
19 hearing doesn't get reported timely, and we have to
20 figure out a way to get that information to us. Just
21 understand the challenges that we have.
22 MR. ARYE: Right. And I think the idea
23 would be to just follow the clients so that you see
24 what happens to them over time.
25 MS. GRANT: We're tracking this as well.

37

1 We're looking at how the policy is playing out. It's
2 not unimportant to us either.
3 DR. SPITALNIK: Thank you.
4 Gwen.
5 MS. ORLOWSKI: Hi. Gwen Orlowski, Central
6 Jersey Legal Services.
7 So I have a couple comments/questions. The
8 first is I completely understand the problem you're
9 describing with the first two quarters of data, that it
10 was co-mingled. The problem I see is that everybody
11 who was moving from the 1915 C waivers into MLTSS all
12 had to go through a redetermination process within that
13 first six months. So they received those reductions in
14 services, some terminations during the third and fourth
15 quarter of 2014 and so that may skew that these numbers
16 are looking like because there might have been
17 significant. It would be really great if we could just
18 get something of that, some of that data, understanding
19 that that data isn't perfect data.
20 MR. ARYE: We're trying. I'm just going to
21 say we're trying. It's very difficulty to really do
22 that. I can also say I don't believe that -- when
23 people came through, there was a continuity of care for
24 services, and the issue came back that even when they
25 were being reviewed that they were supposed to, you

38

1 know, that there was nothing, they continue to receive
2 services all the way through until the very end. I
3 don't believe we heard of many appeals, decisions that
4 a person actually lost services. In fact, the biggest
5 issue and the reason why we put the exceptions process
6 in was because the ones that we were seeing were the
7 PDNs and the cost thresholds, which is why we put in
8 the exceptions clause.
9 MS. ORLOWSKI: I will just say anecdotally,
10 I started hearing them in my previous job in October,
11 that that's when people started reaching out getting
12 both the PCA reductions and the PDN.
13 The next is sort of an observation. It's
14 interesting to see the data this way, but when I think
15 of the annual cost threshold analysis, I really think
16 of that as a separate appeal right because it isn't
17 necessarily exclusively PDN. Right? You could have
18 somebody who is receiving -- it really is, is the
19 person hitting that cost cap and therefore needs to go
20 through that exceptions and appeal process? It could
21 be a balance of PDN and PCA hours. And it could be
22 also that they're having other related services, you
23 know, whatever, home-delivered meals, whatever else
24 they're having. And so I just sort of offer that up as
25 a thought. It's a challenging thought, I think, but

39

1 hitting that cost cap seems distinct for me from
2 challenging a reduction in PDN. And I don't know if
3 the data can be broken out that way going forward.
4 And a question on the exceptions. Do you
5 have plans to formalize that in any way through either
6 a Medicaid Communication or regulations or something
7 like that so that that information is more freely
8 available to everyone?
9 MR. ARYE: First of all, it's in the
10 contract, in the January contract. We did send it out
11 to a variety of places when we initially did the
12 interim. Once CMS approved it, it took us a while to
13 get there, but we did send it out. So it is in the
14 contract.
15 MS. ORLOWSKI: And the last very quick
16 question. I think somebody brought to my attention
17 that all the final agency decisions are now on a
18 website that you guys are maintaining as opposed to
19 Rutgers where it used to be.
20 MR. ARYE: That's correct.
21 MS. ORLOWSKI: And can we also get the
22 initial agency decisions, as well? Because sometimes
23 the substance is really in those initial agency
24 decisions. The final agency's decision will uphold the
25 decision of the Administrative Law Judge, so the

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1 factual and legal analysis is really in that interim
2 decision.
3 MS. HARR: We'll have to consult with our
4 legal office.
5 MS. ORLOWSKI: They were on the Rutgers'
6 site.
7 MS. HARR: Okay.
8 DR. SPITALNIK: Thank you.
9 MS. LIEBMAN: Evelyn Liebman, AARP. I want
10 to thank you all for the presentation.
11 I think it would be helpful to see perhaps
12 in the future meetings of how we're doing on
13 rebalancing in terms of cost. So we're now toddling,
14 as you say, and part of the goal here of the
15 demonstration is to see whether or not we can provide
16 better quality of care at lower or perhaps the same
17 cost. So I've been trying to find out how we're doing
18 in that way. It's great that we're seeing almost 37
19 percent of people accessing services in their own
20 community. But it also would be very helpful to see
21 how we're doing, are we shifting the dollars.
22 MR. ARYE: I think the Balancing Incentive
23 Program (BIP) data is probably the best way to do it.
24 We can certainly look at that, to presenting that. I
25 can also say that it's also difficult, especially given

41

1 that last year the nursing home industry got an
2 additional chunk of money into the budget, so it's kind
3 of hard to really look at that. That's why it's not
4 just expenditures to look at, but you also have to look
5 at the percentage of people who are getting home
6 community based services versus nursing facilities,
7 because the dollars aren't just the only -- there's two
8 pieces to that.
9 MS. LIEBMAN: I agree, there are two pieces,
10 but it would be good even with qualifications, budget
11 changes, to see where we are.
12 MR. ARYE: One more quick thing. So this is
13 the retroactive cost share. MCOs have begun to
14 implement the retroactive processing of claims from
15 July 1, 2014, through December 30, 2015, for assisted
16 living facilities and nursing facility providers based
17 on the corrected patient pay liability. Providers
18 should have received it. If they haven't, they'll
19 receive it very shortly, communications from the MCOs
20 specifically on this. So each MCO is different in the
21 way in which they're providing. That's why we've
22 listed each of the four MCOs. And I'm saying four
23 because AETNA was not in MLTSS prior to or during this
24 retroactive time, so that's why they're not listed
25 here. So specific questions should go to those

42

1 specific MCO contact folks because they're the ones who
2 are handling this. And basically, any corrections with
3 regard to the PPL, any further claims, as well, they
4 need to be adjusted because there may be corrections
5 that were done by the county welfare agencies
6 specifically. So if there is a change in the PPL by
7 the county welfare agency for an individual at any time
8 of the year, it's reflected in the cost share info that
9 the State shares with the MCOs. And the MCOs will then
10 apply that updated information to future claims. So I
11 just wanted to get that information out to you. We
12 have been working with the MCOs specifically on this
13 specific issue. I just wanted to make sure that we
14 gave you that.
15 DR. SPITALNIK: Thank you for all that
16 information.
17 What we do at the end of every meeting is to
18 raise the agenda items that came up during the meeting
19 in planning for the next meeting. And while the last
20 meeting felt very close, the next meeting feels
21 somewhat far away, but it's part of our annual
22 schedule. We'll meet again on October 19th here.
23 What I have, and I'd ask other members to
24 identify things, is that things that were raised as
25 future items, not necessarily able to be on the agenda

43

1 for October, was more details in terms of the interim
2 management unit at Rutgers Behavioral Health, more
3 details of the management of Medicaid services.
4 A point was made about the mental health
5 block grant and the importance of information in the
6 interim setup coming to that, and also the request for
7 stakeholder input, as we're in a redesign phase of how
8 Behavioral Health will be handled.
9 We'll keep track of the provider
10 credentialing, but we certainly have a very successful
11 effort. And we'll look for an update on the ACOs.
12 There was interest in MLTSS in having more
13 information within the 0 to 64 age group.
14 I'd also like add for the next agenda an
15 update on the Balancing Incentive Program. It would
16 seem appropriate to have an update from the Division of
17 Developmental Disabilities on the Supports Program as
18 part of the comprehensive waiver, and also from the
19 Department of Children and Families on their three
20 waivers.
21 There was interest in additional information
22 to the extent that it's available around the appeals
23 and grievance process and also data on migration from
24 MLTSS, and also to the maximum extent feasible,
25 rebalancing data. We have the population numbers, but

1 they're interest in both continuing to have that
2 information and whatever financial information can be
3 brought to bear in terms of the waiver.
4 Other items for our agenda?
5 Beverly.
6 MS. ROBERTS: The transportation RFP.
7 DR. SPITALNIK: That will be an update, yes.
8 MS. ROBERTS: And then when Valerie was
9 giving her presentation, there was some Q and A where
10 she wasn't sure of the answer. If she could respond to
11 those questions in giving her presentation next time,
12 that would be very helpful.
13 DR. SPITALNIK: Thank you.
14 SPEAKER: To the extent possible, a
15 description of changes in the MCO contract that take
16 effect in July, and discussion perhaps of the main
17 points of the CMS management proposed rule.
18 DR. SPITALNIK: Thank you.
19 I really want to commend the Department and
20 the Division of Medical Assistance for the quality of
21 the information and the clarity of the presentation and
22 PowerPoints. It's very helpful. Let me reiterate that
23 those will be posted by the end of today on the
24 website.
25 Do I have a motion to adjourn?

1 Roberts. Second, Whitman.
2 All those in favor?
3 MEMBERS: Aye.
4 DR. SPITALNIK: We are adjourned. Have a
5 good, safe summer. We look forward to seeing you
6 October 19th. Thank you.
7 (Meeting concluded at 11:45 a.m.)
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1 CERTIFICATION
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