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

Wednesday, July 18, 2018
10:11 a.m.

FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, Ph.D., Chair
Theresa Edelstein
Ryan Goodwin
Beverly Roberts
Wayne Vivian

Members Not Present:
The Honorable Mary Pat Angelini
Sherl Brand
Christine Buteas
Mary Coogan
Dorothea Libman

STATE REPRESENTATIVE:

Meghan Davey, Director
NJ 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/.

Meeting Attendees

Benjamin Levy	AARP
Crystal McDonald	AARP
Cheryl Reid	Aetna Better Health of New Jersey
Cathy Chin	Alman Group
Brian Atkisson	Association of New Jersey Chiropractors
Jennifer Black	Beacon Health Options
Hilary Pearsall	Camden Coalition
Tara Porcher	Centers for Medicare & Medicaid Services
Carla Cangemi	Children's Specialized Hospital
Cindy Green	Children's Specialized Hospital
Janet Giordano	Children's Specialized Hospital
Cheryl Golden	Cumberland County Board of Social Services
Al Kizar	Data Motion
Michael Brower	Disability Rights of New Jersey
Shelly Samuels	Easter Seals New Jersey
Liza Gundell	Family Resource Network, Inc./Autism Family Services NJ
John Indyk	Health Care Association of New Jersey
Lillie Evans	Horizon NJ Health
Chis Czvornyek	Hospital Alliance of New Jersey
Brian Shott	Hospital Alliance of New Jersey
Carol Katz	Katz Government Affairs
Anne Weeks	Liberty Dental
Cynthia Spadola	Mental Health Association of New Jersey
Sarah Lynn Geiger	NJ Association of Health Plans
Debra Wentz	NJ Association of Mental Health and Addiction Agencies
Paul Blaustein	NJ Council for Developmental Disabilities
Mercedes Witowsky	NJ Council on Developmental Disabilities
Shabnam Salih	NJ Office of the Governor
Noah Glyn	NJ Office of Management and Budget
Victoria Cook	NJ Office of Management and Budget
Jennifer Uberti	Ocean County Board of Social Services
Sam Weinstein	Princeton Public Affairs Group
Mary Kay Roberts	Riker Danzig Scherer Hyland & Perretti, LLP
Kristen Lloyd	Rutgers Center for State Health Policy
Jennifer Duffy	Sellers Dorsey
Julie Caliwan	The Innovations Collaborative
Zinke McGeady	Values Into Action New Jersey
Connie Dominguez	Weisman Children's Rehabilitation Hospital
Tiffany Forest	Weisman Children's Rehabilitation Hospital
Kathy Hall-Olsen	Weisman Children's Rehabilitation Hospital
John Kirchner	Well Care
Lisa Knowles	WellCare
Madeline Taggart	WellCare
Linda Bongiovanni	WellCare
Stuart Dubin	WellCare
Robin Ford	NJ Department of Health
Michael Cenna	NJ Department of Health
Richard Goldin	NJ Department of Health
Valerie Mielke	NJ Department of Health
Adam Neary	NJ Department of Human Services

Stacey Callahan	NJ Department of Human Services
Elizabeth Brennan	NJ Division of Aging Services
Heather Smith	NJ Division of Developmental Disabilities
Freida Phillips	NJ Division of Family Development
Carol Grant	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services
Julie Cannariato	NJ Division of Medical Assistance and Health Services
Steve Tunney	NJ Division of Medical Assistance and health Services

DR. SPITALNIK: Good morning. Welcome, to all you dedicated souls who are not at the Jersey Shore today. Welcome to the July 18, 2018 Medical Assistance Advisory Council (MAAC) meeting. I want to clarify that pursuant to New Jersey Open Meetings Act, adequate notice of this meeting has been posted in compliance with the requirements of the New Jersey Register.

I also need to tell you as guests in this building that in the unlikely event of an emergency or the need for evacuation, upon hearing the fire alarm or an announcement, we will quickly leave the building via the nearest exit, go to Lamppost No. 9, and there you will report to Phyllis Melendez who will check our names off a list.

So I'm delighted to welcome you. For new attendees, let me explain our procedure very briefly. We begin with introductions. We ask the members of the MAAC to introduce themselves. We are delighted that there are so many members of the public and stakeholders here. We will then ask you to introduce yourself and to speak very loudly. We will then, as part of our agenda, turn to the approval of the minutes. We'll have two presentations on the Delivery System Reform Incentive Payment Program (**DSRIP**), Neonatal Abstinence Syndrome (NAS), and also the Medicaid Innovation Accelerated Program (IAPs). We will

then have a series of informational updates on NJ FamilyCare (NJFC), Managed Long Term Services and Supports (MLTSS), and Non-emergency Medical Transportation (NEMT).

We have prided ourselves on the ability to have interaction with stakeholders throughout the course of the meeting. When we have a topic presented, the members of the MAAC ask questions first or make their comments. We will then turn to you as stakeholders and members of the public, invite you to make comments. We ask that you make very concise comments. We've been very glad that we've never had to limit public comment to isolated periods, either at the beginning or the end of the meeting, but rather to have true dialog. And I hope that can continue, but we do reserve the right to make sure that we get through our agenda appropriately.

So with that series of guidelines, let me ask the members of the MAAC to introduce themselves. And then we'll turn to the members of the public.

When you do make comments, please say your name clearly for the benefit of Lisa Bradley, who we are very appreciative of our documentation of our meetings, and we'll go from there.

(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Thank you all. I know that

this takes some time, but I think it provides us an understanding of the breadth of involvement and interest and really helps revitalize or invigorate our dialog.

As we are lacking a quorum, we can't approve the minutes at this time.

Is there anything that anyone would like inserted in the minutes at this time, or shall we postpone that to our October meeting? What's your pleasure? Comfortable postponing that?

Okay. Thank you.

And we'll now turn to presentations. Our first presentation is on New Jersey Plan to Sustain and Reform the Delivery System Reform Incentive Payment Program, and I'm delighted to introduce Robin Ford who is the Executive Director of Office of Health Care Financing for the New Jersey Department of Health (DOH).

Everything that's shown here is then, after the meeting, posted on the Division of Medical Assistance and Health Services (DMAHS) website. So these presentations are available to everyone.

Welcome, Robin Ford, and thank you for joining us.

MS. FORD: Thank you very much, everyone. Good morning. It's nice to see so many familiar faces in the audience.

My name is Robin Ford, and I am the Executive Director of the Office of Health Care Financing in the Department of Health.

One of the programs under our office is the Delivery System Reform Incentive Payment Program, or more affectionately known as DSRIP. Many of you are familiar with DSRIP, I'm sure. But today I'm here to talk about the DSRIP Sustain and Transform Program. It is intended to begin in July 2020 as the successor of the current DSRIP program. But first let me briefly talk about our current DSRIP program.

(Slide presentation by Ms. Ford)

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

MS. FORD: That's the end of my presentation. Does anyone have any questions?

DR. SPITALNIK: Robin, thank you so much. And thank you for acknowledging the stakeholder input, which is, I think, one of the strengths of this.

In terms of questions, does anyone on the MAAC have questions?

Beverly Roberts.

MS. ROBERTS: First of all, thank you very much

for this.

So I noticed that under the connections to care pathway and objectives, Behavioral Health is mentioned. And I also know that it's a priority for the Governor to improve autism services here in New Jersey. I'm wondering if there's been any discussion about having a focus on individuals with autism and other intellectual and developmental disabilities (I/DD) as part of this proposal?

MS. FORD: We haven't gotten to that level of detail yet, but it's something we should definitely consider. And as we're doing the Quality Measures Committee, I'll reach out to you, and hopefully we can get someone on there that has an expertise. So thanks, Beverly, for bringing that up. I appreciate it.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Anyone else from the MAAC?

Anyone from the public?

Debra Wentz. I'll ask you to stand and your name.

MS. WENTZ: I'm Debra Wentz from NJAMHA. My question is also on the connections to care when you're looking at improving follow-up care and access to medications and treatment and addressing the social determinants. I'm just wondering in terms of looking at

different pathways and payment systems, that's been one of the limitations of the current DSRIP program. And we were hoping that with the successor program there would be a true integration with Community Care and that it would be focused so that people, after getting their care, would be able to maintain their health in the community or recover in the community, as well. So I think that that piece, we'd be happy to provide input or cull together a stakeholder group to give you input as to what would look like. I know that within our own association many of our hospital-based members were a little frustrated, even those had in the first generation of DSRIP chosen different, like, Addiction or Behavioral Health focused experiences because there was no incentive to engage community partners, yet they were relying on them.

MS. FORD: Thank you for that feedback. It's definitely feedback we've heard. I appreciate it.

MS. WENTZ: Thank you.

DR. SPITALNIK: Thank you.

Anyone else?

Robin, thank you so much. We look forward to hearing. Our next meeting is after the September 30th submission deadline, but we hope that you'll come back with an update.

MS. FORD: Gladly.

DR. SPITALNIK: Thank you.

We're now turning to presentations on Neonatal Abstinence Syndrome. We're welcoming colleagues both from Weisman Children's Rehabilitation Hospital (Weisman)and Children's Specialized Hospital (Children's Specialized). And Kathy Hall-Olsen is going to start us off.

Welcome, Kathy.

MS. HALL-OLSEN: Thank you.

Good morning, and thank you for inviting myself, Kathy Hall-Olsen, Hospital Administrator for Weisman Children's Rehab Hospital, as well as my colleague from Weisman, Tiffany Forest, who is our Director of Social Work and champion for Neonatal Abstinence Syndrome; and Dr. Connie Domingo, our Medical Director from Weisman Children's Rehab Hospital; along with our colleagues from Children's Specialized who include Dr. Carla Cangemi, the Medical Director of the Infant and Toddler Program; Janet Giordano, the Director Care Coordination; and Cindy Green, the Director of Referral Development.

We are thrilled to be here today to talk to you a program that's near and dear to our hearts. Together, we would like to talk about how we can best serve the growing needs of population of infants and children, young children, in the growing context of the opioid crisis as

it exists in New Jersey. But first well discuss our objectives here today.

We want to provide you with an overview what Neonatal Abstinence Syndrome is, provide some information about the national impact, as well as some local initiatives that are currently occurring in the State of New Jersey; provide you with information about the NAS programs at both Weisman Children's Rehabilitation Hospital, as well as Children's Specialized; and then talk about some current obstacles in terms of servicing this population, projections for the future, and some exciting longitudinal research that is being conducted by Children's Specialized Hospital at this time.

But first, before we go too much further, I also want to add one more piece of information. Many of you may not know Weisman Children's Rehab Hospital. We are one of two pediatric rehabilitation hospitals in the State of New Jersey. We service primarily southern New Jersey, but we do treat patients in the tri-state area. We have nine programs for pediatric populations; NAS is one of those. In addition, we have five outpatient programs throughout southern New Jersey, and three medical daycare programs.

(Slide presentation by Ms. Hall-Olsen)

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DR. SPITALNIK: Thank you so much. And we're very grateful both for the presentation and the work you're doing.

We'll turn to Children's Specialized and Dr. Carla Cangemi, and then we will have questions for both programs afterwards. I think that will provide a more integrated approach.

Welcome.

DR. CANGEMI: Hi, my name is Dr. Carla Cangemi, I'm the Director of the Infant and Toddler Team at Children's Specialized Hospital.

Just briefly, our institution consists of our Inpatient Rehabilitation Center in New Brunswick. We have outpatient sites. As you can see here, there are 12 New Jersey locations. And usually that consists of neurodevelopmental, outpatient neurology, psychiatry, and all forms of therapy, outpatient therapy. Going back, we have two long-term sites in Toms River and in Mountainside.

(Slide presentation by Dr. Cangemi)

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available for viewing at http://www.state.nj.us /humanservices/dmahs/boards/maac/)

DR. SPITALNIK: Thank you so much. And I would invite the MAAC to ask questions of both Children's and Weisman. I know there are other members of the team present, so they may respond.

So I'll start with Wayne.

MR. VIVIAN: What if it's determined or the mother is not able or it's determined that the mother should not or cannot provide those bonding activities. What happens to the child then? Do they still take the child into treatment and let somebody else provide or do that.

DR. CANGEMI: We will provide that care. No matter what, our goal is for the patient but also support the parents. We have found that if they're not able or just not ready at the present time to support their child during that time, that's when we have child services that are involved to kind of help the support, so they're there.

MR. VIVIAN: So you have somebody come in as a surrogate?

DR. CANGEMI: As a surrogate --

MR. VIVIAN: Like, to provide the bonding.

DR. CANGEMI: Yes, the bonding, yes. So if they're not there -- let's say, a lot of our families might

need assistance with transportation, for example. But if they physically can't be there or emotionally can't, we have surrogates or we also have volunteers, many volunteers like cuddlers that provide that bond to the patient to help.

MR. VIVIAN: Thank you.

DR. SPITALNIK: And please, our colleague from Weisman, please introduce yourself again and respond.

MS. FOREST: Hi. I'm Tiffany Forest, I'm the Director of Social Work at Weisman Children's Rehab Hospital and also the NAS Program Champion. And much like Children's Specialized, if the part cannot be there or is not going to be the one taking the baby home, we do have involvement of the Division of Child Protection and Permanency involved. And then there are people at the hospital that are able to provide those bonding experiences for the baby through way of our public program and also rehab aides and nursing aides and things like that. But when the baby is awake, the baby has somebody with them.

MR. VIVIAN: Do you have any idea about how often that happens?

MS. FOREST: Well, 84 percent of our babies go home. And for the ones that are going home, the parents are involved, they are there. If the mom can't be there,

then it's usually a grandmother or someone that is present. Our parents do go out for treatment every day, so that it's someone with them. But there can be times when the baby is not going home and we have those periods where DCPP is looking for a family. There can be some days or a week or so until they establish a foster home that the baby does not have someone there with them on a daily basis, but we provide a bonding staff.

MR. VIVIAN: My concern is like more for the parents. Obviously, I'm concerned about the child; that's a given. But how successful is the -- since I work in mental health and substance use and all that, how successful would you say the parents' recovery is, that they do become good parents and are able to provide a nurturing environment, they're able to get off the substances and stop using?

MS. FOREST: Well, that kind of links to our percentage of those children that are able to go home.

MR. VIVIAN: But I wonder how many are able to stay there. Like, how successful is the parents' abstinence.

MS. FOREST: We only follow them 90 days out.

DR. CANGEMI: That is a good question. It's something to look at. But I have to say about 25 percent end up with a resource parent. The additional parents,

the ones that actually are discharged home, are usually in a program; and we support them through that program. They'll go once a week and psychology works well with them. But as following the parents as outpatients, I don't think -- that's something that we should look into.

MR. VIVIAN: Yeah, because it reflects on how successful the whole substance use treatment program is. If a child is not enough of a motivating factor for somebody to, you know.

DR. CANGEMI: I guess the program is more geared towards the infant, treating the infant.

DR. SPITALNIK: Kathy, please.

MS. HALL-OLSEN: I think something that's, again, very important and very critical is this factor that, yes, our primary role is with the infant when they come to us as they move through us. But the very critical part is that there has to be handoff. And so handoff care coordination as you go into the community is essential. And we're excited because the State of New Jersey, through Project Embrace, and we have a project called Embrace in Southern New Jersey, our goal is to wrap that care around that family. So once we hand off and we set in motion -- here is your pediatrician, here are the specialists, the therapists that you're going to go see -- we also touch base and know in our case, with

Southern New Jersey Perinatal Co-Op, they guide the support and I believe they are working on having care coordinators who actually go into the home, check with mom, see that they're okay, to have that ongoing support. It is a grant, so as long as the funding is there, but it's very promising. That is what we've learned. We've learned that we can't be in isolation helping these children. We need to reach moms when they're going to the obstetrician. We need to keep our tabs on the children as go back in the community. And, again, as we mentioned, things like social determines health.

MR. VIVIAN: And you're not able to be there 24/7 to monitor the situation.

MS. HALL-OLSEN: Exactly.

DR. CANGEMI: But I think what's also important to stress is that why we're just such an advocate for having these patients be transferred to our rehabilitation program. There's a lot of facilities that we try to reach out to all the neonatal ICUs within New Jersey about our programs because I think it's a great transition from acute to rehab to heal the patient, but also provide support to the parent, because when they're in the NICU, they're there or, let's say, they'll complete their week for a week. Parents cannot stay in the room. And really, the physician and the nurses don't really

develop a relationship with the parent, so they can't identify those issues because once they're discharged home, there's really no follow-up. So when they're in rehab, we spend a good two to three weeks with them every day. The doctor sees them twice a day; therapy, you develop that relationship. You transition them to outpatient. And then, hopefully, with the outpatient pediatricians and neurodevelopmental pediatricians following them, they can provide support and be the advocate.

So, yes, looking at how successful the parents are, that is something that we can bring back to both institutions to look at. But I think that's why we're just so passionate about this program, coming to rehab.

MR. VIVIAN: Thank you.

DR. SPITALNIK: I have two questions, and one of which was -- and Meghan just informed me -- was the connection to other services; Early Intervention and Home Visitation, which is under the Division of Family and Community Partnerships in children and families.

Meghan, do you have an update on the Home Visitors?

MS. DAVEY: Right. So legislation passed to do a Home Visitation Pilot in New Jersey which we're -- I think Julie presented at the last MAAC on where we were

with a waiver amendment that we're using to get the authority to do this Home Visitation Pilot. So that is with the Centers for Medicare and Medicaid Services (CMS) right now, but this aligns exactly with what our Home Visitation Pilot is for. It's for those at-risk, low-income moms during pregnancy, birth, and when they're coming home. So I think is a nice collaborative. And probably we need to coordinate our efforts as we get approval from CMS.

DR. SPITALNIK: I had an additional question which is a probably highly technical one. Is Neonatal Abstinence Syndrome then reflected in the electronic birth certificate?

UNIDENTIFIED SPEAKER: That, I am not sure of.

DR. SPITALNIK: That would be good to find out because that has implications for longitudinal follow-up and surveillance. So we'll turn to our colleagues in the Department of Health at some point and find that out.

Other questions from MAAC?

Theresa.

MS. EDELSTEIN: First of all, thank you both for great presentations.

I have two questions. The first is do you know, since you both provide pediatric medical day care or have provided pediatric medical day care, what

proportion of these children end up in your pediatric medical day care program following discharge? Do you have any idea?

MS. FOREST: Really, for us, it's not many of our children unless they have a co-occurring feeding disorder where they have an NG tube and then we're able to have that qualify for payment through Medicaid for medical day cares. I know that has been something that we have been trying to do and pressing for so that they can have that one-year follow-up with nurses with eyes on them and then continue to have that support through the social workers and the therapists in our medical day cares. But so far, Medicaid has not supported the qualifications for just NAS.

MS. EDELSTEIN: So as a policy matter, I think it's something that Medicaid and the Department of Health should look at as a potentially good vehicle for good care coordination since it's, in many cases, within the same provider. And it also provides a tremendous amount of support to the family.

MS. FOREST: That would be fantastic.

DR. CANGEMI: That would be helpful because with medical day care, it's usually NGT dependent, nasal gastric dependent, if they have a tracheostomy, NG tube, or medical needs.

MS. EDELSTEIN: Medically fragile children.

DR. SPITALNIK: And from Children's, would you also reintroduce yourself?

MS. GIORDANA: I'm Janet Giordana, I'm the Director of Patient Care Coordination and Social Work. Yes, everything that my colleagues here just said, too. At a minimum, if a child does have seizures, a history of seizures, that would be the lowest level. So sometimes with the other issues that these little ones are kind of experiencing, we can kind of skate them in sometimes. But, yes, it would be so incredibly needed and helpful.

The other thing that we do also, too -- and I'm sure Weisman does as well, too -- is a lot of the insurance companies will also connect the families with the care coordination through insurance companies, as well, too. So there is a different eye on them, as well, through the insurance side that is also another kind of connection. So I'm not sure if any of the insurance companies are doing any type of longitudinal studies as well, too, but it is a different connection that all the families get, as well. So as long as they're voluntary with it, usually they are, they want as much help as they can.

MS. EDELSTEIN: My second question is also more policy related, but thank God you're there for the growing number of babies and moms who have these issues.

But as we look forward and look at prevention, what role have your programs played so far? What do you think you'll play in working with obstetric practices to identify women early in their pregnancy so that when baby comes, maybe recovery is well on its way and they're not as compromised at the start of their life?

MS. FOREST: So I know for us down in southern New Jersey with the Southern Jersey Perinatal Cooperative and some community leaders down in Cape May County are trying to gather obstetricians and educate them and present the programs that are available in the State and then also educate the moms also through that and then through the methadone programs, as well, so that they're educated earlier so that the doctors are more vigilant and able to help the moms. So we are working to do that and bring all the practices together, but, you know, it is difficult, but we are trying to do that in Southern Jersey. Perinatal Cooperative is the driver for that and we're working with them.

DR. SPITALNIK: That also may be something that Medicaid can have a role in, both in terms of the Home Visitor Program, but also more broadly the DCF, Department of Children and Families Division of Child and Community Partnerships, which was originally called the Division of Prevention. But that may be an important linkage that

maybe Medicaid can help convene.

Beverly.

MS. ROBERTS: So I agree with the comments that Theresa and Debra have just made, and in particular, hopefully, Medicaid will be able to do whatever needs to be done maybe on the contracts with the MCOs for the medical day care for these young children.

My question, before having heard Theresa, has a lot to do with referral into your programs. Dr. Cangemi referred to it a little bit. But can you just talk about how do the moms find out about your programs? The ones that are in need, so they're in the hospital, babies may be neonatal, how does that next step take place for referral?

DR. CANGEMI: As far as the NAS getting into the program? So getting into the program is through when the patient is diagnosed as having NAS. That's in the neonatal ICUs around New Jersey. How do they know about it is we're trying to do outreach as much as possible to all the neonatal ICUs to kind of explain why it's so important to have a baby identified with NAS be transferred into our or both institutions once they're stabilized on their medication regimen for usually day of life number seven and then transfer to us.

And then first day of admission when they're

in is just constant education or follow-up. So we have family faculty that plays a role in that, as well. Family faculty are family members that are employed by Children's Specialized but once had a patient that was hospitalized at Children's Specialized. So they're a parent advocate. So they do a lot of outreach and education to the parent about the programs that we have; outpatient pediatric practice if they want to stay within the system if they can. Not everyone lives within that vicinity. But then also in terms of early intervention and neurodevelopmental pediatrics. And before leaving, appointments are made so we kind help them not stress them out so they have a list of appointments already made and referrals given to them to make it easier.

Just going back to also visiting nurses: We also provide a visiting nurse for at least a month, two times a week for a month to continue the continuity of care and follow-up.

I hope that answers your question, but it's just our team educating when they arrive.

MS. ROBERTS: So for Weisman, is it a similar response?

MS. FOREST: Yes, a similar response, but we also go out to the methadone clinics and we educate the moms and the counselors there that, you know, we have this

program, this can be your experience. And also we go out to the different hospitals and educate them, as well. When we do get a referral, we have our nurse liaison go out the same day or the next day to educate the moms and give them, you know, what's your experience would be like at Weisman. But I could say for the most part our referrals come from the community, from the mom saying, "I want to go to Weisman," because she's heard about us through the methadone clinic or friends that have had babies before. Because everybody needs patients, so our hospitals do refer to us, but most of them come from personal, you know, the moms saying, "Please refer me to Weisman."

MS. ROBERTS: My second question is, with the Managed Care Organizations, do you have affiliations with all of the five MCOs in New Jersey?

MS. GIORDANA: As for insurances, yes.

MS. ROBERTS: For the coverage.

MS. GIORDANA: Yes, we have contracts with all the insurances.

MS. FOREST: We do. For us, but I think we have a very difficult time with Amerigroup recognizing the NAS program and approving for NAS.

MS. ROBERTS: That's a concern, but hopefully something can be done. I'm not sure if anybody's here

today from Amerigroup.

DR. SPITALNIK: I think our role is to refer that to the Division of Medical Assistance and Health Services in our advisory capacity. And I know that they will follow-up. But we're not in a position to in any way intervene in that process.

DR. CANGEMI: Can I just comment? I just want to comment on one thing.

DR. SPITALNIK: Sure.

DR. CANGEMI: I think our biggest goal is to educate the acute care facilities so they can identify that need of the program, because it's not just weaning and sending home and then the parent is sent home without the support. So I agree reaching out to the methadone clinics, as well, but I think it's the acute care facilities, the neonatal ICUs across New Jersey, that really needs to understand the epidemic, the needs of the patient and the family, and transition to a safe discharge. And that's not really done in acute care facilities. And our stakeholders should understand that, as well, you know, the amount of work that's needed while they're in inpatient rehab going home, because our ultimate goal is safety and having our children meet their full potential. So I think that's a big key.

MS. ROBERTS: Thank you very much.

DR. SPITALNIK: Thank you.

Questions from the public?

Thank you so much for what you're doing and wonderful presentations.

(Applause.)

DR. SPITALNIK: We will now turn to the section we call presentations on the Medicare Innovative Accelerator Program and Technical Assistance Opportunities.

Julie Cannariato.

MS. CANNARIATO: Thank you very much to the MAAC for inviting me back to give an update on the Division's work under the Medicaid Innovation Accelerator Program, Technical Assistance Opportunities. I know most of you have probably heard me talk about this before. And throughout this presentation, I'll commonly refer to them as the IAPs.

(Slide presentation by Ms. Cannariato)

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

DR. SPITALNIK: Thank you, Julie.

I'll turn to Wayne with his question.

MR. VIVIAN: Yes. My question is in reference

to the simulation of the bundled payment regarding children's asthma. Are you hoping to find that a bundle rate would offer more flexibility and more effective services? Is that you would get just as much reimbursement and the providers would have more flexibility and were you able to provide more flexibility under a bundled rate?

MS. CANNARIATO: So I think it's both. We get this question asked a lot, especially by CMS. Are we looking primarily for cost savings in a bundled payment or are we looking to that bundled payment to raise quality?

MR. VIVIAN: And flexibility.

MS. CANNARIATO: And flexibility. And I think our answer is always it's both. We want to do both. I mean, we always want to be able to -- as a stakeholder and as a steward of the State, we are always budget conscious. But I think our priority there is really around quality metrics. We're wondering if the bundled payment will offer that increased flexibility to provide a provider a menu of services under one rate.

MR. VIVIAN: Now, let's say it proves true, that it's successful. Could that model be used in other areas? Would you consider or are there plans to use it in other areas?

MS. CANNARIATO: So that is the plan. So

given everything equal and we see positive results which we're hoping for, as Tennessee has done, they've used that model to overlay different ideas. So I think they have something around joint and chronic care that they're using some Medicare data. We started with pediatric asthma. We're talking about maybe overlaying some diabetes data. There's all these ideas around Value-Based Purchasing. But, yes, the model with some tweaks, we could use to overlay some other chronic conditions or targeted populations.

MR. VIVIAN: Like Behavioral Health?

MS. CANNARIATO: I would say probably on my menu, Behavioral Health would probably be a little bit more into the future just because all of the movement that there's been moving from the Cost Base Reimbursement to Fee-for-Service (FFS) to Managed Care. I would say we'd probably hold off on a little bit of that for right now. I would assume we would try some other things that are already within our managed care plans right now.

MR. VIVIAN: Thank you.

DR. SPITALNIK: Other questions?

Theresa.

MS. EDELSTEIN: Julie, I may have missed this in my MLTSS Steering Committee world, but can you provide the MLTSS Steering Committee with more detail the success

the plans have had that you referenced under the first Value-Based Purchasing?

MS. CANNARIATO: The incentivizing quality of them?

MS. EDELSTEIN: Yes.

MS. CANNARIATO: Sure.

MS. EDELSTEIN: Because I don't think the Steering Committee has heard any of that information. We rarely hear about the performance of the managed care organizations (MCOs) at our Steering Committee, so that would be a nice piece of information for the Steering Committee to have.

MS. CANNARIATO: Sure. We're happy to provide that. I'm not sure when the next Steering Committee meeting is.

MS. EDELSTEIN: September. End of September.

MS. CANNARIATO: I'm sure Carol will be happy to get that update.

MS. EDELSTEIN: You'll have other things on your mind.

DR. SPITALNIK: Thank you.

Yes? Would you stand and also tell us your name?

MS. ABRAMS: Mary Abrams, New Jersey Association of Mental Health and Addiction Agencies

(NJAMHAA). I just wanted to clarify. From Wayne's question, you said that the Behavioral Health bundled rates would be more in the future. With the one proposed that you have, you said mental health substitute Fee-for-Service value-based. So you're talking value-based other than bundled payments?

MS. CANNARIATO: Yes. That would be other than bundled payments. It's really in the conceptual phase right now. So I think when we started looking at diabetes purchasing, because New Jersey is 96 percent managed care, we were focused more on how diabetes purchasing works in a managed care context. But some of our colleagues at Mental Health and Addiction had approached us, and we thought it might be a good idea even on the ground, boots on the ground learning, to figure out, hey, here's an opportunity to possibly work with Value-Based Purchasing and Fee-for-Service environment and how would that possibly look. A lot of our other colleagues around the country have had some success in a Fee-for-Service environment and having a direct relationship with the provider. So we put together a very high-level general outline of what we related the technical assistance on. But in terms of bundled payments for Behavioral Health, Behavioral Health is still carved out of our Managed Care plans except for the small pieces

that are going to be going in in October. But it would be more of a general look at how that would work in Fee-for-Service environment. There's no specific plan around a different payment model at this time.

DR. SPITALNIK: Thank you.

Anything else?

Julie, thank you so much for this wonderful presentation.

We're now going to turn to a series of informational updates. And as we do at every MAAC meeting, we'll turn to Meghan Davey for the NJ FamilyCare.

MS. DAVEY: It's always good to update everybody. So good morning, still.

(Slide presentation by Ms. Davey)

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

DR. SPITALNIK: Thank you.

Questions from the MAAC?

Hearing none, questions from the public?

Hearing none, I thank you for the update.

And we'll turn to Elizabeth Brennan who is the assistant Division of Aging and Services (DoAS) in the

Department of Human Services for an update on Managed Long Term Services and Supports.

Welcome, Elizabeth.

MS. BRENNAN: Thank you. So as a continuation of Meghan's presentation, this is an update on the MLTSS enrollments.

(Slide presentation by Ms. Brennan)

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

DR. SPITALNIK: Thank you so much.

Questions from the MAAC?

Questions from the public?

As always, thank you for this wonderful presentation. And I think you brought us new clarity to the information, and we appreciate it.

I'll now turn to an informational presentation on Non-Emergency Medical Transportation overview. And we'll look to Steve Tunney who's Chief of Behavioral Health and Customer Service.

Welcome, Steve.

MR. TUNNEY: Thank you.

So the last time I presented, I told you things that we were going to go. So I'm going to try and go over

the results of that now.

(Slide presentation by Mr. Tunney)

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

DR. SPITALNIK: Steve, thank you so much.

Questions from the MAAC?

Theresa.

MS. EDELSTEIN: So thank you for this. This is helpful. Two questions:

Would you be willing to come back in October and talk about the results of the report?

MR. TUNNEY: Sure.

MS. EDELSTEIN: And the second question is, can you also share with us at some point in the future the level of penalties that have been assessed according to the parameters in the contract?

MR. TUNNEY: Yes. I can get that.

MS. EDELSTEIN: Great. Thank you.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Yes. Thank you for this. It's very helpful.

Are you able to determine if some of the problems are repeat offenders, specific drivers or

companies who are problems over and over again?

MR. TUNNEY: That's another area that we asked LogistiCare to look at closely because I say where there's smoke, there's fire. And if the same individual keeps getting a certain complaint that you can't validate like being rude and things, then they are doing -- they put people on the ride and then they will complete that ride and then they evaluate the driver. They're doing things along those lines. I now get a copy of every single complaint that comes in, and we can break it down. We can sort and filter to see if it's particular drivers, if it's particular providers, the companies. And that, I did in our last meeting with LogistiCare. I asked them about a particular provider that there was an awful lot of complaints. All of a sudden, the number of complaints had just gone up. It was related to a separate issue that they're having. But we are looking at that information, as well.

MS. ROBERTS: Good. Thank you.

DR. SPITALNIK: Anyone?

Yes?

MR. INDYK: John Indyk of the New Jersey Health Care Association.

Your denials, is it possible to break that down by community-based denials versus facility-based denials?

MR. TUNNEY: Yeah, I can probably do that.

MR. INDYK: That would be helpful. And there's some legislation pending now that I think failed to differentiate problems that may occur in the community versus the long-term care facility. And I make that point that a lot of these complaints and whatnot are probably more community based versus facility based complaints. Like the facility requests a transport, not the individual. So this legislation requires that the individual certify that they need the transport to get to medical care. The facility is making that decision. So I think you need to differentiate that, community versus what's going on in the facilities. I think that would be helpful to break that down.

DR. SPITALNIK: Thank you.

Steve, as always, thank you so much.

We've come to the end of our agenda. Our next meeting is October 17th.

And the items that I have culled from the requests so far for our agenda is an update on the DSRIP process.

Theresa had a request for the MLTSS Steering Committee in terms of the Innovation Accelerator Program.

We have, as always, an update on NJ FamilyCare, on MLTSS. I would add the autism spa progress to date,

and then a request for the IPRO report on LogistiCare and transportation.

Are there other items?

Beverly.

MS. ROBERTS: The Division of Developmental Disabilities Dual Diagnosis Pilot. It's been discussed in the past, but it would be really good to get an update on that.

DR. SPITALNIK: Okay.

Other items?

The other thing is that we will then do the minutes of our last meeting. Hopefully, not being in summer, we'll have a quorum.

Unless there's anything else, do I have a motion to adjourn?

MS. ROBERTS: Motion to adjourn.

MS. EDELSTEIN: Second.

DR. SPITALNIK: I experience consensus here.

Again, I want to thank Phyllis Melendez and Meghan Davey and the staff of the Division and Lisa Bradley for her notes.

Good and safe and healthy summer, everyone. Thank you for coming.

(Meeting adjourned at 12:19 p.m.)

CERTIFICATION

I, Lisa C. Bradley, the assigned transcriber, do hereby certify the foregoing transcript of the proceedings is prepared in full compliance with the current Transcript Format for Judicial Proceedings and is a true and accurate transcript of the proceedings as recorded.

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