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

July 20, 2017
10:09 A.M.

FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Sherl Brand
Mary Coogan
Beverly Roberts
Wayne Vivian
Sidney Whitman, DDS

Members Excused:
Theresa Edelstein
Dorothea Libman

STATE REPRESENTATIVES:

Meghan Davey, Director
Division of Medical Assistance and Health Services

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

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

ATTENDEES:

Deb Charette	Autism New Jersey
Evelyn Liebman	AARP
Cheryl Reid	Aetna Better Health New Jersey
Donna Bouclier	Alliance for the Betterment of Citizens with Disabilities
Patrick Gillespie	Amerigroup
Brian Atkisson	Association of New Jersey Chiropractors
Thomas Papa	Bellwether Behavioral Health
Lucia Buffaloe	CBIZ, Inc.
Molly Ennis	Camden Coalition of Healthcare Providers
Hilary Pearsall	Camden Coalition of Healthcare Providers
Tara Porcher	Centers for Medicare & Medicaid Services
David Kostinas	David Kostinas and Associates
Matthew Kostinas	David Kostinas and Associates
Hannah Wallach	Disability Rights of NJ
Liza Grundell	Family Resource Network
John Indyk	Health Care Association of New Jersey
Karen Brodsky	Health Management Associates
Heather Watson	Horizon NJ Health
Chris Czvornyek	Hospital Alliance of New Jersey
Mark Connelly	Katz Government Affairs
Gwen Orlowski	Legal Services of New Jersey
Cynthia Spadola	Mental Health Association of New Jersey
Donald Langan	Medical Society of New Jersey
Amanda Cortez	Medical Transportation Association of New Jersey
Price Abrams	MWW
Phillip Lubitz	National Alliance on Metal Illness of New Jersey
Wardell Sanders	NJ Association of Health Plans
Maureen Shea	NJ Association of Community Providers
Debra Wentz	NJ Association of Mental Health and Addiction Agencies
Kevin Casey	NJ Council on Developmental Disabilities
Paul Blaustein	NJ Council on Developmental Disabilities
Dennie Todd	NJ Council on Developmental Disabilities
Alison Gibson	NJ Department of Health
Kate Clark	NJ Family Planning League

ATTENDEES:

Grace Egan	NJ Foundation for Aging
Crystal McDonald	NJ Health Care Quality Institute
Colleen Picklo	NJ Hospital Association
Selina Haq	NJ Primary Care Association
Kim Higgs	NJ Psychiatric Rehabilitation Association
James McCracken	Office of the Ombudsman for the Institutionalized Elderly
Karen Shablin	Optum, Inc.
Samuel Weinstein	Princeton Public Affairs Group
Davon McCurry	Princeton Public Affairs Group
Mary Kay Roberts	Riker, Danzig, Scherer, Hyland & Perretti, LLP
Colleen McLaughlin	Rutgers University, Boggs Center
Jennifer Farnham	Rutgers Center for State Health Policy
Ronald Poppel	Sunovion
Tony Severoni	Sunovion
Raquel Jeffers	The Nicholson Foundation
Michael Simone	United Healthcare
Zinke McGeady	Values Into Action NJ
Lisa Knowles	WellCare
Nancy Tham	Wellcare
Madeline Taggart	Wellcare
Roxanne Kennedy	NJ Department of Human Services
Liz Shea	NJ Division of Developmental Disabilities
Freida Phillips	NJ Division of Family Development
Marie Snyder	NJ Division of Family Development
Jennifer Gavin	NJ Medicaid Fraud Division
Kay Ehrenksantz	NJ Medicaid Fraud Division
Michelle Andrews	NJ Division of Medical Assistance and Health Services
Linda Edwards	NJ Division of Medical Assistance and Health Services
Meghan Davey	NJ Division of Medical Assistance and Health Services
Phyllis Melendez	NJ Division of Medical Assistance and Health Services
Maribeth Robenolt	NJ Division of Medical Assistance and Health Services
Marc Gonzer	NJ Division of Medical Assistance and Health Services

DR. SPITALNIK: Good morning. Welcome to the July 20, 2017, meeting of the New Jersey Medical Assistance Advisory Councill (MAAC). I'm Deborah Spitalnik, the Chair of the Council. It's my pleasure to welcome you.

The notification for this meeting was filed pursuant to New Jersey's Open Public Meetings Act, with adequate notice of the schedule for quarterly meetings.

It's my responsibility, as we are guests in this auditorium, to remind people that in the unlikely event of an emergency evacuation, quickly leave the building by the nearest exit. Go to the Lamppost in the parking lot, No. 9, and we will check off your names from the attendance sheet; which is a good opportunity to remind people to sign-in on the attendance sheet. You can do that as you're leaving, but it helps us keep a record.

Let me review our procedures. We will start with introductions. I will ask the members of the MAAC to introduce themselves. I'll then ask the members of the public to introduce themselves and their affiliation. That's not a point of time for public comment.

We have prided ourselves as a Council on our ability to have dialog with the public, butt in order

to accommodate that, our rules are that the MAAC members get to make comments and ask questions first. We will then open the floor to questions from the public related to the topic. We reserve the right to limit the time of that and also, if necessary, to have to resort to a particular public comment period.

Our comments need to be confined to the agenda. And, again, I want to reiterate the role of the MAAC is to advise the Medicaid Program and the Department of Human Services about the Medicaid Program.

So with that, again, let me turn to my colleagues up here, ask them to introduce themselves. We'll then go to the public. I'll ask you to speak loudly.

And our thanks to Lisa Bradley, our recorder. So when you do make comments, please identify yourself by name if you're a member of the public.

I know that's probably more rules than a sports game, but we'll start with Dr. Whitman.

(Members of MAAC introduce themselves.)

(Members of the public introduce themselves.)

DR. SPITALNIK: Thank you all for coming. We very much appreciate your being here.

Our first agenda item is to turn to the April 13 summary. And I turn to the MAAC for additions, corrections and/or a motion to approve.

Beverly.

MS. ROBERTS: Just one very small correction on page 21 of thee summary, there was a comment from Mr. Spielberg. The word that's typed here is "Presentation and your commitment to helping Medicare." The word should be "Medicaid."

DR. SPITALNIK: Thank you. That correction is noted.

Any others?

And Beverly, for your careful reading of it.

Do I have a motion to approve the summary?

Motion, Roberts; second Whitman.

All those in favor?

MAAC MEMBERS: Aye.

DR. SPITALNIK: The summary of April 13th is accepted, with thanks to Lisa Bradley and Phyllis Melendez.

We now turn to informational updates. And our first item is the transition of Mental Health Services to Fee-for-Service. And I want to welcome Roxanne Kennedy who is the Director of the Behavior Health Management for the New Jersey Department of

Human Services.

Welcome, Roxanne. Thank you for being with us.

MS. KENNEDY: Good morning, everyone. I'm usually last on the agenda, but I got to be first today so I'm very excited. Everybody is awake and not tired.

I'm talking about the transition of Mental Health Services to Fee-for-Service. The impact of this is the state dollar and transition is state dollar for cost base contracts to Fee-for-Service system, much like Medicaid pays for services, and helping our providers have a system in which they can do that.

(Presentation by Ms. Kennedy)

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

DR. SPITALNIK: Thank you so much.

Are there questions from the MAAC for Roxanne?

Questions from the public?

Thank you so much.

We'll now turn to Elizabeth Shea, Assistant Commissioner of the Division of Developmental Disabilities (DDD), the Department of Human Services,

for an update from the Division of Developmental Disabilities.

Welcome, Liz.

MS. SHEA: Thank you.

Hi, everyone. So, I think I come to most of these meetings; there are so many of you that I know at this point in time. I'm going to give an update. I'm going to spend most of the time on where we are in Fee-for-Service (FFS) because I think that's primarily what people are interested in. But, I think because I haven't done this part in a while, I'm just going to give a little bit of an overview of the some of the reform.

(Presentation by Ms. Shea)

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

DR. SPITALNIK: I want to start off with just one informal question.

MS. SHEA: Sure.

DR. SPITALNIK: When you projected full enrollment in the Supports Program in 2019, approximately how many individuals do you project?

MS. SHEA: 9,000. And that's a good

question because, if you were to look right now at DDD's numbers, just by the numbers, we have about 26,000 people in our system, and we have 12,000 in our Community Care Waiver (CCP). But, if you subtract that, you're not going to get 9. There's going to be more than 9. There are a number of people in our system that remain DDD eligible or become eligible. It's always been a big group like this who never really ask for a service. They become DDD eligible, and for whatever reason they're not coming to the state for any services. So until someone presents for something, we wouldn't enroll them. So there will always be some group that sits out there. If they present, then they'll get enrolled in the Supports Program. The idea is that once we get full enrollment, anybody new that newly presents to our system gets enrolled directly onto the Supports Program.

DR. SPITALNIK: And if they were presenting to the system because their parents had died or were no longer able to provide care, would they go to the Supports Program or the CCW?

MS. SHEA: Fabulous question.

So as of today, if somebody presented new today -- and let's say we'd already enrolled everybody onto the Supports Program -- because of our regulatory

process, they would have to be declared an emergency before I could enroll them on CCW. But as long as they met those criteria, then they would be enrolled.

My hope, and I think the reform effort, the movement forward, is that we won't have -- the waiting list would get eliminated as we sort of move through the rest of this. And, at that point in time, we'll be able to literally, as people enter, sort of funnel them right away to the appropriate services.

Right now, I have a waiting list for the CCW. So without declaring someone an emergency, I have no legal authority to put them right on. But, we do that all the time.

DR. SPITALNIK: Thank you.

Sherl.

MS. BRAND: Just a quick question on the New Jersey Comprehensive Assessment Tool (NJ CAT). So you've got the notification letters that went out. The deadline is July 31, 2017 which is right around the corner. Any sense of the percentage that have not been completed? And is there a plan to do any additional outreach for that void?

MS. SHEA: Since this letter went out, 21,000 have completed them, which is good. We're pretty close to what we think is the number of people

receiving services today. I don't expect people that not getting services are going bother with it. So I think we're already close.

In terms of the ones that we need, we are not certain; but, we can get information back to you. But the follow-up is weekly. We have a weekly check-in meeting around where are we on the NJ CAT. We have staff whose job it is to continue to make the calls, work with case management, and work with supports coordination. There's a lot of work into that, for sure.

DR. SPITALNIK: Beverly.

MS. ROBERTS: Thank you. It was an excellent presentation.

A couple of questions: Private Duty Nursing (PDN) plus Supports is wonderful. We greatly appreciate it. Every once in a while I talk to a family, and the child is on the CCW. And they would like to have CCW plus PDN. As of this moment, they can't. Do you see a time after the CCW has been incorporated into the 1115, -- just for a small number, but everybody that we can help, we want to help -- that we will be able to have CCW plus PDN?

MS. SHEA: So, I think the experience we have in Fee-for-Service and the data of what happens

will really bear that out. If we need it, yes, I think we have a great model for it now. So, I don't think it would be that hard to design. I think the way our current system is structured is that individuals who would need that level of nursing would already get the acuity factor in our rate process. When they got tiered, they would get the higher tier based on the need for that nursing. So, that largely should cover that already. And, they can take that budget whether they're going to a provider, or they're in the home, and utilize it. So again, my hope is, that would get covered for the vast majority of people, but if we need, if there's still a gap, we absolutely will do that. That makes complete sense. And there may be; we don't know yet until we start to actually transition people.

In our old system, because we don't have those level budgets particularly for in-home people, we have a disparate situation, right? We have out-of-home services get reimbursed at a higher level and people that are receiving them in the home get an in-home budget that's lower so people can't purchase the same stuff. I think over time we'll know.

MS. ROBERTS: Because what's happening right now is that if somebody finishes school -- and they've

had private duty nursing when they're in school. Now they're 21; and they want to come to DDD. If today they are CCW people, what they're being told is, "Well, you have to dis-enroll from the CCW, go onto Supports if you're going to have your PDN."

And so for parents, that's --

MS. SHEA: Again, I think we're going to have to see how it plays out. I know a couple of those instances. And a couple of those instances are, again, for today for what the person needs, they can get all their needs met in that way so it's okay. Other people choose Managed Long term Services and Supports (MLTSS). Again, I think we just need to start doing it a little bit and see. But if there's a gap, we will fill it in. That's our job.

MS. ROBERTS: And my second question has to do with Medicaid eligibility on one of the last slides, what families need to do. So I don't think it's going to be as much of an issue getting Medicaid eligibility initially. You need to have that or you're going to be a non-Disabled Adult Child (non-DAC). But, then there is some people who lose it down the road afterward for a variety of reasons. And I'm concerned as to whether Support coordinators are going to be really on top of it, because parents won't necessarily know exactly

what's happening and why. And we don't want a gap. We certainly don't want a gap. But that's a concern that I have.

MS. SHEA: On that, we have a couple of things already built into our electronic system to account for that. We have flags that get sent to Support coordinators on a monthly basis. So there are things already built in, but we're talking all the time about ways we can kind of beef that up. Again, I share that's a concern. I think it's going to be an on-going issue for our provider community. It's sort of like all-hands-on-deck, right?

We all have to be cognizant of making sure that that continues to happen, but we do have some stuff already built in. I'd be happy to talk to you later about what we have already, and if you have any ideas.

MS. ROBERTS: Thanks.

DR. SPITALNIK: Any other questions from the MAAC?

Any questions from the members of the public?

Kevin.

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

A couple of things, Liz. The ability to bring all kids out of special education into the Supports Program is an achievement that you ought to be very, very pleased with. And there are only 49 other states that probably need to do something similar. I think that's a very good start to that.

A little bit of a concern I have is that -- and this is a little bit related to what Beverly was saying. You're going to have a group of folks within that Supports Program that can't get their needs met within the Supports Program. And the question is, are we going to create a waiting list for them to get into other programs? Are we going to have a planning process in place if that were to occur over time? Any thoughts on that?

MS. SHEA: If over time we find that between our two waiver programs we're not meeting needs. And, we would need another waiver program, then that would be something, I guess, we would look at then. Sort of in the meantime, I think certainly the vision is that people can have their needs met by one of the two. And if you can't today have your needs met on the Supports Program, we have processes to get you to CCW today. You just have to meet that emergency determination.

Like anything else, it comes down to the

definition of "you can't get your needs met." If it's, "I would like more of this at this a moment in time," but we don't determine it's urgent enough, then you get on the waiting list. The good news is our waiting list was 8, 9,000 people not long ago, and we're down --I mean, we're moving people so rapidly off that at this point in time that I think even if someone got on the waiting list today, and they just waited, they may never become an emergency because the amount of time they'd have to wait before they could look at CCW enrollment would be different. However, I think a bigger part of that is maybe not as popular of an answer but is true, is that there are people that don't meet the criteria, don't meet the level of care. Under the Community Care Waiver, you have to meet an institutional level of care. So if somebody comes up and they want or feel like they need additional service and they don't meet that level of care, then it becomes a matter of, "Well, what?" And that's why I had that slide in there about the other service delivery systems which, again, I know isn't a popular thing to say. People like to be able to say, "I just want to be under DDD and have it managed there," but we have to get to a place that people are accessing the supports and services that you can access, like any other population

in other areas of the state. So I think we have done a better job, especially training our support coordination agencies about helping people to access those things. So, I think those are the two answers to that.

MR. CASEY: Then there are the fiscal intermediaries, we've gotten some calls, as I'm sure you have, expressing concerns about confusion in that. It's hard for us to tell exactly how widespread the concerns are because, obviously, people who are happy don't call. Do you have any feel for that in terms how widespread is the confusion? Are there a lot of families who are upset and confused? Is it a predominant thing?

MS. SHEA: It's a good question. I would start by saying that the number of people that it impacts -- and that's not to minimize the issue -- but the number of people that it impacts on the scale of who DDD serves is a very small universe to start. So, we'll start there. There's a smaller universe there. Within that universe, my impression is that the confusion was the whole universe and probably even beyond them. So the confusion, I think, was wide. We definitely had customer service-related issues. We had people calling and having to call multiple times.

There were some bumps.

But in terms of it actually impacting people, my sense is it's a very small number of people that are impacted other than being really irritated and confused. And, to be clear, I'm not minimizing that either. But the impact, I think, is very little. And I think we've managed at this point. But we're still working through it today. As of yesterday I still had someone I was working with on something. So it's not done yet, but we're close, very close.

DR. SPITALNIK: Thank you.

Other questions from the public?

MS. ORLOWSKI: Gwen Orlowski, Legal Services.

First of all, thank you all for the excellent presentation. I just have to say on small personal note, I remember going to the public advocate nearly a decade ago on that waiting list issue, and you should really be very proud.

MS. SHEA: Thanks, Gwen. It's good to see you.

MS. ORLOWSKI: Good to see you, too.

So I have a question that goes back to the housing voucher. I have a couple of questions, so I'll give them and then let you answer them.

The first question I have is whether or not that same system is going to work for people who are in the Traumatic Brain Injury (TBI)community residential services programs.

MS. SHEA: Can I answer that first? And then you'll have your others. Is that okay?

If someone who -- I don't know the answer to what's happening by anything not funded by DDD. So people in MLTSS, I don't know. There are certainly many people with TBI who are getting services funded through DDD. I just met with a provider yesterday that does some of these homes. And if they're enrolled in the Community Care Waiver and they happen to have a traumatic brain injury and are funded by it, then certainly, they would get a housing voucher that way. But if it's outside of our funding, that's different. If it's sort of in the MLTSS world, there are others that would have to answer that.

MS. ORLOWSKI: I don't know who from MLTSS that's present. Maybe they can touch on that, if that is happening there as well.

DR. SPITALNIK: That's later in the agenda. So we can hold that question. Thank you.

MS. ORLOWSKI: And then following-up, I had written down a question about the Home and Community

20

Based Settings Rule and implementation of that but then you addressed that. I have a couple follow-up questions. Do know that the Centers for Medicare and Medicaid Services (CMS) delayed the transitions that were supposed to be complete, I think, in 2019. And I'm wondering how that plays in with New Jersey's timeframe for these residency agreements. And then as part of those residency agreements and having protections under the landlord tenant laws in New Jersey, what is going to be the mechanisms for people to do that? Landlord tenant court? I assume not. Or something else to enforce those rights.

MS. SHEA: That's a lot. I'll do my best.

I think part of the larger question of what's going on in New Jersey related to the Home and Community Based Settings Rule and our Statewide Transition Plan, this is what I'll say.

So when the Home and Community Settings Rule came out, we, like every other state, struggled with what does it mean? We didn't get a lot of guidance early. I think it just took some time. By the time we got guidance, we were, again, like many other states, heading in different directions around it. We put out a draft plan. We received an enormous amount of feedback, really almost exclusively on the

21

Developmental Disability (DD) side from the DD providers around it. We made some adjustments. We put out a new plan and made some adjustments again. We had public hearings last summer. There's been a lot of discussion around it. Then it was submitted to CMS. And we're still waiting on that.

In terms of how things will adjust, I'll just say that -- it's really a statewide plan, so I can only speak from the DDD side of things. But I think that at this point in time there was so much discussion or upheaval related to what was that Settings Rule going to mean to people with developmental disabilities, nationally. Then, everyone kind of settled into something. And then, a new Administration came, and now what does this mean? So, I think I would say from where we sit at DDD -- again, I can't speak for the whole state -- but from where we sit, we're not looking to make a lot of policy changes until we have a better sense of where things are headed because we can't keep diverting people into different directions and say, "This is an okay place to live. Oops, sorry, now you have to be here. Oops, sorry, now it has to look like this."

So, we're trying to be a little bit careful. It's a little bit of a waiting game I think at this

22

point in time to see how things pan out nationally around the issue.

Obviously, the basic tenets of the Home and Community Based Settings Rule -- I don't think anybody doesn't agree with. But this one where it really comes down to the devil's in the details of how you implement it. And I learned firsthand that there's a lot that you have to think about when you go through that. So, again, we're a little bit on hold, I think, about doing a lot of implementation, except for when it comes to the residency agreements piece. That's essentially the settings part. When it comes to people signing leases or residency agreements, because we're making this shift right now, this is the time. People are beginning to get housing vouchers, so if we don't do this now and then a year from now say, okay, everyone we just did another shift, now we want to go back and now make you sign leases. So we're just doing it at the same time.

The mechanism for how they're going to get enforced really is an interesting, I think, open-ended sort of legal question. And there are some national organizations that have been looking at it. But, you know, I don't know that that's a decided area yet. We can talk a little bit more after this meeting, if you

23

would like.

Maribeth.

MS. ROBENOLT: Maribeth Robenolt, Office MLTSS Quality Monitoring, Division of Medical Assistance and Health Services (DMAHS), Just to make a distinction with Gwen's question.

MS. SHEA: Yes, go ahead.

MS. ROBENOLT: The individuals who were DD residing in group homes are still responsible for their contribution to care. A housing voucher is above and beyond that and addresses the previous contractual arrangement.

MS. SHEA: I don't know if you all could hear that. And I actually left this out earlier, so I will say this because it's important.

So the way that the system works today is that if you're residentially placed and receiving DDD services, you have to pay 75 percent of your income back to the state for what's called contribution to care. As we shift into Fee-for-Service, like I said, people will have access to a housing voucher. However, the contribution to care, the way it was before, goes away. What instead happens is they pay 30 percent of their income towards their housing voucher and then the rest gets handled by the Supportive Housing Connection,

but then they're retaining 70 percent of their income and that's an individual arrangement that providers are setting up with their families around what percentage or flat fee, whatever that's going to be, has to get collected then to handle some of those other costs that were previously getting offset that aren't anymore, such as utilities and food and it really varies based on the provider.

DR. SPITALNIK: Liz, can we clarify? When you say income, is it Social Security Income (SSI)?

MS. SHEA: All income. All income together, so SSI plus whatever people have when people are working, et cetera. And with that, people get very concerned. "What if I have zero? What do I do?" Well, 30 percent of 0 is 0. So, that's fine. Then the Supportive Housing Connection fills in the rest. It still gets handled.

DR. SPITALNIK: Thank you.

Other questions?

Yes?

MS. SAIDEL: Sue Saidel, Disability Rights of New Jersey.

We've had some folks who have had NJ CAT finished and they either leave the state or they disagree with it and they're being told that you can't

be re-assessed for a year. While we appreciate trying to get all the people who haven't had their assessment have that done and gone, that seems to be a problem. Is that --

MS. SHEA: No, I think the misunderstanding is this. People are who enrolled in Fee-for-Service already, meaning they're already enrolled in The Supports Program, or they're maybe on CCW side and are getting enrolled right now. If you're getting services that are paid for based on your NJ CAT score, you have to be able to get re-assessed immediately. And we have a process for that that's laid out in our manuals.

The people that we're putting on hold are the people that aren't using it yet because we still have so much work that we're doing with the others. So if the idea is you're not going to get enrolled in Fee-for-Service until November and you have an issue with your NJ CAT score, we might say to you, "We can't re-do your NJ CAT until closer to your enrollment because we've got so many others," but it doesn't impact anyone's actual service, right, because it has to get done before that change. I think some people are worried about it so they want their re-assessment now. We just literally don't have the capacity internally to do a re-assessment for everybody right

now that wants one. So we're doing them as they need to be done. But, again, if it doesn't impact your service system, we will do the re-assessment before it certainly would have any impact in one way or the other.

DR. SPITALNIK: Thank you.

MS. ROBERTS: I just want to clarify what I just heard. Thank you very much, because I did not know this. So if somebody is already getting service and they feel that they need to have a re-assessment on the NJ CAT, what do they do in order to have that done immediately.

MS. SHEA: If they're already in a service and they're enrolled in Fee-for-Service, meaning it has some impact so, someone that is in a group home today who have their NJ CAT done and they come out and they think their NJ CAT is wrong, for whatever reason, but they're not converting to Fee-for-Service, meaning their assessment won't impact anything about them, right, until December, closer to that time they will be allowed to go through the re-assessment process. If someone today is in The Supports Program, it's impacting them today. If their tier is wrong, their budget is impacted by that, or once they get enrolled in the CCW. If you're already in that zone, there is a

process in both of our manuals, The Supports Program manual and the CCW manual that tells you exactly how to do that re-assessment.

MS. ROBERTS: Thank you.

DR. SPITALNIK: Well, thank you so much for the excellent presentation. We'll try to think of questions for next time. Thanks.

We now turn to an update or NJ FamilyCare with Meghan Davey, the Director of the Division of Medical Assistance Health Services.

MS. DAVEY: We'll provide our general update for you.

(Presentation by Ms. Davey)

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

DR. SPITALNIK: Thank you so much.

Other questions or comments?

Beverly.

MS. ROBERTS: Thanks for update. I'm a bit surprised about the LogistiCare contract award. I'm guessing some other people here are as well. There have been a lot of concerns in the past. Is there anything that you can say about improvements that

LogistiCare has said they will make?

MS. DAVEY: Well, if you look at the Request for Proposal (RFP), we put a lot of requirements in RFP to make sure that we were addressing the concerns over the last many years of work with the transportation broker. So, we can outline those for you, including requiring the Global Positioning System (GPS) in all vehicles so that they'll have that real-time data to know a driver was there on time or not, and the timeframes surrounding the transport. There are many improvements the RFP that will have to be in place under the new contract.

MS. ROBERTS: Perhaps maybe for the next meeting there could be very specifically what they are being held to and what the public can do to complain if need be.

MS. DAVEY: Okay. That sounds good.

DR. SPITALNIK: Any other questions from the MAAC about NJ FamilyCare?

Any question from the public about Meghan's presentation?

Seeing none, thank you so much.

We'll turn to Carol Grant, the Deputy Director of the Division of Medical Systems and Health Services for an update on Managed Care.

Carol, welcome.

MS. GRANT: I thought maybe we would start with some updates on grievance and appeals and fair hearings numbers. I will discuss the core portion of Medicaid and Maribeth will do the MLTSS portion.

(Presentation by Ms. Grant and Ms. Robenolt)

Any questions?

DR. SPITALNIK: Beverly.

MS. ROBERTS: So you had the appeals numbers. Did those go to a fair hearing? Do you have any hearing data?

MS. GRANT: We do not have the ability to cross-walk and track one case from complaints, grievances, and appeals all the way through to the Office of Administrative Law's fair hearing process. I think we've discussed that in past meetings. I've provided the kinds of cases that went to fair hearing, but I'm not sure that you can track going from a specific case to a fair hearing.

MS. ROBERTS: But the fair hearings that Carol just gave us, 355, that number, and 227 were withdrawn.

MS. ROBENOLT: The time period that Carol gave was six months. January to June of 2017. The period that I just reported on was July through

December of 2016. So it's not even the same period of time.

MS. GRANT: I'm hoping as we put a new Medicaid Management Information System (MMIS) in place, and other kinds of things that we'll be able to do a better job of following case all the way through the internal and legal system, wherever it goes. And frankly, right now we're going to move to a simplified appeals process due to new federal rules where you've got an internal level of appeal at the health plan, maybe an independent utilization review, and then a fair hearing. So, we're going to figure out how to cross-walk the reporting of what we used to have where we included complaints which will no longer exist as an informal level of hearing to a more formal internal hearing which has to be exhausted before the fair hearing process can begin. I have a feeling the new rules will enable a more simplified reporting mechanism for DMAHS.

MS. ROBERTS: Again, going back to the 227 that were withdrawn, so more than half were withdrawn. Do you we know anything about that, the withdrawn?

MS. GRANT: I think it's fairly routine. Very often, what happens is somebody files, they may submit, or their provider submits additional

information, and the case is decided and they no longer feel as though they need a fair hearing. I don't think that we would be able to speak to each one of these. I don't have that information. But it is something that as we've reviewed fair hearing data in past MAAC meetings, we do see that very often people start a process but then the issue gets resolved.

MS. ROBERTS: Anecdotally -- and other people may have other anecdotal experience -- it's withdrawn because whatever it was that was denied previously, it's then allowed. And that accounts for what's withdrawn. That's anecdotal experience.

MS. GRANT: I think anecdotally, I would agree with you; that often is what happens. Or, keep in mind, additional information is submitted, or simply needs change which impacts a withdrawal as well.

MS. ROBENOLT: Or a negotiation takes place.

MS. GRANT: Certainly; and, that's not something we would want to stop.

MS. ROBERTS: No. But I think it might be good to know what happens to such a large number.

MS. DAVEY: Maybe we can look at a sample.

MS. GRANT: Yes, maybe we can drill-down on some of them, at least.

MS. ROBERTS: Thank you.

MS. GRANT: I know one of the MAAC members -- Mary Coogan, I think it was you -- asked questions about the child core set quality measures. And I just realized that I had gotten just a little more information which I will share with you from the podium.

Of the 26 child core set measures that CMS has, annually Medicaid actually reports on 18 of those. Two CMS via their Medicaid and CHIP Program (MACPro) system, which is CMS reporting system, 16 of the 18 are actually the Healthcare Effectiveness Data and Information Set (HEDIS) metrics. So, we do track the required HEDIS performance metrics routinely and it shows up in our annual performance report that we publish. They're still voluntarily, but we do report on them and we do use them for quality purposes. Anytime we have HEDIS metrics that falls below the National Committee for Quality Assurance (NCQA) 50th percentile as a benchmark, we require our health plans to submit a work plan. And those submissions are due on or before August 15th of each year. So we do use them for quality purposes.

Thank you for the question.

DR. SPITALNIK: Is that something that we'd want to put on the agenda to see what those measures

are?

MS. COOGAN: Yes.

DR. SPITALNIK: So, when we recap the agenda at the end, we'll look towards those for October.

MS. GRANT: I'm just going to go through some of the changes in the NJ FamilyCare utilization appeal process.

(Presentation by Ms. Grant)

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

DR. SPITALNIK: Carol, thank you.

Any comments?

Beverly.

MS. ROBERTS: Thanks very much, Carol.

So, some obvious concern about the 10-day issue, which is not very much time. And if it's 10 days from the date of the letter, it's not uncommon for somebody to receive a letter that's significantly after the date that was on the letter. What can be done about that?

MS. GRANT: The issue has been raised with us. We're actually taking a look at it. Remember, we're still dealing with 120-day time frame, so we

don't want to hold people up. We always take those things into account. Our own research seems to indicate that the letters definitely are issued on the date they are dated. It doesn't mean it always happens. We're taking this under consideration to see how to address it. By providing more time, but you don't want to let people wait too long such that it infringes on the 120-day timeframe. I would say duly noted on that issue we're trying to see what we can do.

MS. ROBERTS: I'm very concerned in particular for continuation of benefits because anecdotally what I hear about most often is either Personal Care Assistant (PCA) or PDN and for the continuation of those services if families don't even quite know and if it gets mailed out on a Thursday or a Friday and then a holiday -- I mean, all sorts of things where they might get it at a point where they have hardly any time.

I would also hope that the letters would be very clear in bold print to continue benefits, bit noticeable bold about the 10 days. Some people see a letter and they don't quite know what it is and how to understand it --

DR. SPITALNIK: Thank you. Other questions? Gwen.

MS. ORLOWSKI: Thank you so much. We're one of the agencies that have a lot of concerns, echoing what Bev said about the 10 days, a couple things about that. Number one, the federal law which is the general fair hearing law also governs here, and that requires 10 days from the date on of mailing, not the date of the letter. So knowing when a letter was mailed is of utmost importance. In order to do that, you need a postmark. I will tell you some of Managed Care organizations use bulk mail and doesn't have a postmark, so that's one of the things. I think under federal law it does have to be 10 days from the date of mailing, so that seems like an easy fix. Though I would advocate for the 20 days. It's historic within 20 days for all the reasons that Bev was talking about. Ten days for our clients is just not enough time with the transit of mailing to get it and to be responsive. So I think we're going to see a lot people being hurt by this unless we go back to the 20 days.

I also want to point out that, if I understand correctly, you need to do that also for the appeal. What you have to do first and sometimes that's very difficult. I know the letter for fair hearing is now going to fax. Thumbs-up on that. But, for example, with United Healthcare you have to mail

something to Utah to request it. So that can be very difficult if people have to request this in writing. And that timeframe just is not long enough.

Some of us would like an opportunity to talk with you more about how to perfect what is an improved letter, but see if we can make it a little bit better.

One of the things when I was at Legal Services of New Jersey about six years, I met with Nancy Day specifically on the issue of including a copy of the assessments with all adverse actions related to assessments. And there was an agreement back then from the Division of Aging that that would be done. And there's case law that supports it that that's what you need to do to comply with due process. I don't see any reason why the managed care companies can't include a copy of that PCA assessment along with a notice that is an adverse determination with respect to their PCA services. And making people call for that is an undue burden and I think unconstitutional.

MS. GRANT: I just want to point out that the contract does require that members get a copy of that assessment at the time that it's done, or it must be mailed.

MS. ORLOWSKI: That's not happening.

MS. GRANT: That's something that we

definitely need to know about if that's not happening because that's really very important. We would like to see examples, but I'm making a note of it because we're taking everything under consideration. This is a new process.

MS. ORLOWSKI: I understand that. I have one other point that I raised before and I think it's critically important in the MLTSS context. People frequently know about what services they're going to get through the plan of care process, right, when they sit down and a plan of care is developed and they're signing off on it. They do not understand that that plan of care includes individual services that they actually have fair hearing rights. You go to a plan of care meeting and you say, "I want 30 hours a week. That's what I think my needs are from PCA and there's a determination that the plan of care is 20." People feel obligated to sign that plan in order to get the services moving. They don't understand that that under the federal law is an adverse determination. They've made a request for more than the services that are included in the plan. I think every plan of care needs to have a notice of adverse determination that spells out people's rights to have a fair hearing. And so I would recommend that because otherwise they don't know

that they have that opportunity.

MS. ROBENOLT: Gwen, just on that last point. That's something that you've raised previously here at the meetings and that's something we have taken back and are looking to incorporate some language similar to that.

MS. ORLOWSKI: Thank you.

MS. COOGAN: Something Gwen just said. Did you say the letters go out bulk mail?

MS. ORLOWSKI: I just look at a series of them from a client. I'm calling it bulk mail. I'm not a post office --

MS. COOGAN: The only reason I'm asking -- and maybe somebody could clarify, because my understanding with bulk mail, it doesn't necessarily go out the same as --

MS. ORLOWSKI: It may not be bulk. It's a mail that doesn't have a postmark on it. I mean, I'm happy to look at what the envelope -- I have several of them in my office right now.

DR. SPITALNIK: So the issue is that there's not a date that it was mailed that's apparent.

MS. COOGAN: And bulk mail is different than first class mail.

MS. DAVEY: And that was one of those issues

where we ask you to please send examples of that because we really need to see that in order to address it, and the different health plans that it's happening with.

MS. GRANT: I think we're all going to have to walk hand-in-hand and make sure that this actually works for people. Right now, you know, it's a process in place. We don't want to mess around with not meeting the kind of requirements we have to, but these are the kinds of ideas I think we really need to hear, I appreciate it.

DR. SPITALNIK: Kevin.

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

I want to, again, express a concern about the complication of this process. And may need to be as complicated as it is; I'm not saying it doesn't. The complication of this process and the ability of individuals and families to kind of understand the process and get through it. I would speculate, by the way, and I admit this speculation and anecdotal, it's my experience that a fair number of folks out there aren't really even aware that they have a right to appeal. I know that the letter that sends a denial out includes information on that.

MS. GRANT: It does.
MR. CASEY: Whether they're focusing on that or not at the time they get a denial is open to some questions. So I would again urge some level of educational process that gives individuals and families a simple flow chart, if you will, of if you're going to file an appeal, you need to do this first and this second and this third, and that kind of thing. It would really be helpful. And I'll again offer that the New Jersey Council on Developmental Disabilities (NJ CDD)(Council) is willing to work with you on that and put some resources into that.
MS. GRANT: We have had talked about this -- some of the plans already do an additional insert to the notice. The thing is we would like to standardize that and make it simple and clear.
We do have the member handbooks. We have a "Making Medicaid Managed Care Work For You" that the Boggs Center led. Maybe we need to take a look at what's in there and maybe build off that. I think we would take advantage of your Council to do that because we expect the plans are supposed to help the member through the process. We have quality offices that help the member. But the most critical thing is to make sure people know their rights and their

responsibilities, but certainly their rights. So we'd be happy to work with you.
DR. SPITALNIK: We're beginning the process of doing more consumer education about Medicaid, so we'll commit to doing this with you for review. And review with the plans as well, and then disseminate it.
MR. CASEY: Just a detail question. I was hoping Liz would be here when I asked this. But is there a separate appeal process for the DD waivers than for other Medicaid programs?
MS. ROBENOLT: The appeal process that we're discussing here is related managed care and the Managed Care Organizations (MCOs). For anything else that's a Medicaid-covered service, I know formally a fair hearing is the one way to handle it.
MS. GRANT: You probably need to address it with Liz.
MR. CASEY: Obviously. I guess I would ask if we could have a presentation on that at some point.
DR. SPITALNIK: I'll make a note.
MS. ROBERTS: Carol, just one more very quick question.
On the external appeal, it used to be that if it was PCA issue that could not go to an external appeal. Is that still the same?

MS. GRANT: It is. And we are having some conversations with Meghan's agreement with the Department of Banking and Insurance (DOBI) about whether we should continue that. I actually have the list of things that actually are not reviewable by the Independent Utilization Review Organization (IURO) because it's a medical necessity review, a peer review. And I think the IURO did not feel it was appropriate for them to address non-utilization-related concerns. However, PCA does require a written order and it must be done by a nurse. So it's something that we're having some discussion about. In general, the kinds of things aren't reviewable are adult day care, assisted living programs and services, caregiver participant training, chore services, community transition services, home-based supportive care, PCA, respite, daily and hourly, social day, and structured day, but we are looking at that, Bev.
MS. ROBERTS: Okay. That would great to get an update if it turns out that that would be allowable because I hear a lot about that particular issue with denials.
DR. SPITALNIK: Anyone else?
MS. JEFFERS: Hi. Raquel Jeffers, The Nicholson Foundation.

So I notice in your presentation about the appeals process there wasn't a single appeal for substance abuse or for mental health services. And yet we know this is an issue in the community, denied services based on medical necessity or other reasons. Obviously, the substance abuse and mental health services are kind of new or some of them are new to the Medicaid umbrella. But I think the point about educating the community, particularly as we bring new services under -- I guess none of them carved in.
MS. GRANT: Some of them are.
MS. JEFFERS: As that happens, it's just something to be mindful of. I was really surprised to see not a single one of the fair hearing requests are for substance abuse or mental health services.
MS. KENNEDY: I think only thing that's managed is MLTSS.
MS. JEFFERS: Right, but even your own -- I mean even if there's a Medicaid appeal.
MS. GRANT: I mean, maybe this is a similar to the DD one, you know, are there options within the DMAHS for appeals, this is through managed care. If it's carved-in service, it would be the same process that we're talking about here. Again, it's a matter of education and making sure people understand their

rights as more and more services get "Medicaid-ized" -- that's my term.

Anything else?

If not, really good questions and good dialog. Thank you.

DR. SPITALNIK: Carol, thank you so much.

We now turn to an update on Managed Long-Term Services and Supports and welcome Laura Otterbourg, the Director of the Division of Aging Services. Laura, welcome.

MS. OTTERBOURG: I have two parts to my presentation. The first one is the slides that you always see updated, what we call the dashboard indicator on MLTSS. So I'll go through these. And then I have another portion of this presentation on an initiative that's under way.

(Presentation by Ms. Otterbourg)

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

DR. SPITALNIK: Questions from the MAAC around the data that Laura just presented?

Questions from the public.

MS. JEFFERS: Hi this is Raquel from The

Nicholson Foundation.

Was I correct reading this line that the actual nursing facilities spend has gone up in 2016 than in 2015?

MS. OTTERBOURG: Well, it probably remained around the same, but you have the nursing home spend for MLTSS which has increased because as the program matures, more and more -- now, anybody who enters a nursing home is under MLTSS, so that's why the nursing home spend has increased under MLTSS. It's a shift. We're not talking about overall Medicaid dollars. We're talking about nursing home dollars under MLTSS, which is natural.

DR. SPITALNIK: Thank you for that question.

Phil.

MR. LUBITZ: Phil Lubitz from National Alliance on Mental Illness (NAMI).

I just wanted to say I appreciate you taking a little bit of a deeper dive into the behavioral health aspects. The availability of the slides? It was kind of quick to really digest the slides.

MS. OTTERBOURG: I think you all get them, don't you?

DR. SPITALNIK: Yes the slides are posted on the DMAHS website under the MAAC at:

http://www.state.nj.us/humanservices/dmahs/boards/maac/. So the presentations are posted after the meeting. And they're not posted in advance to give people the most recent data, data is really to the 11th hour.

MS. OTTERBOURG: Actually, I can attest to that because until this week, I had last month's data, so this was really the most recent data that Medicaid has.

DR. SPITALNIK: But all presentations that are delivered at the MAAC are on the website.

Other questions?

So, Laura thank for this data. And let's go on to your next topic on the Nursing Facility Quality Improvement Initiative.

(Presentation by Ms. Otterbourg)

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

DR. SPITALNIK: Thank you so much.

Sherl.

MS. BRAND: Thanks, Laura. That was a great update. I know you said there was a Workgroup. I'm assuming that that involved representatives from the nursing home industry, as well?

MS. OTTERBOURG: Correct. I can just expound on that. Under the launch of MLTSS there was a whole Quality Workgroup. Some people are no longer in the same positions some people have moved on. So that was a base, but then we asked other people to join on. For example, we reached out to the Ombudsman for the Institutionalized Elderly and we have some consumer advocates participating in this Workgroup and they've provided a lot of feedback, especially around the importance of the resident satisfaction tool. We have a lot of individual nursing homes through the associations. People have given us some people who are really experts in the minimum dataset, which is important for this. The New Jersey Department of Health (DOH) has been participating because they're experts also in the minimum dataset. And they'll have other roles in terms of the nursing side of this.

MS. BRAND: That's great. And thank you for that additional information.

So once it is ready to go, in January 2019, do you envision that this is something that would then -- you referenced public knowledge. So is that something that would be posted on the state website?

MS. OTTERBOURG: What we anticipate, first of all, I mean, it's multifold, but one thing we'll be

working very closely with the nursing trade associations because it's going to involve a lot of training of the nursing home industry. But we'll be working with AARP on webinars and seminars and also the Ombudsman for the Institutionalized Elderly because they have a whole network of consumer volunteer advocates that go out to the nursing homes, so they'll be an important link to the public as well. Momentarily, we need to get the website up as we start rolling this out. As more information is developed, more information will go to the website. But there will definitely be a place on the website as we roll this out.

MS. BRAND: And now my last question is when you say annual designation -- and maybe I missed this in your presentation -- what is the designation?

MS. OTTERBOURG: That they're any willing qualified provider designation.

MS. BRAND: So it's an either they are or are not?

MS. OTTERBOURG: Exactly.

MS. BRAND: Thank you.

DR. SPITALNIK: I have a question. I realize that you're drawing on the flu immunization because it's Minimum Data Set (MDS). Is there any

thought about including pneumonia, immunizations against pneumonia as one the measures? Because that's such a risk factor in the elderly.

MS. OTTERBOURG: I'm not the MDS expert, but I think we can -- this is an original starting point and other measures can be substituted and added at other times. This was a doable, workable start to the project.

I don't know if anything has anything else to add.

There were other measures, too, but these were the ones that we had originally started out with as a Workgroup perhaps because it hits the largest group.

DR. SPITALNIK: And also the MDS is, in a sense, standardized so you can benchmark across states.

But thank you for that.

Yes?

MS. EHRENKRANTZ: Kay Ehrenkrantz, Deputy Director of the Medicaid Fraud Division.

In your envisioning, who will answer these questions? Who would be the people for the nursing home or for the individual?

MS. DAVEY: For the resident survey?

MS. EHRENKRANTZ: Yes.

MS. DAVEY: It could be the member or the family.

MS. EHRENKRANTZ: Who is the source of the data?

MS. DAVEY: Person, the guardian, a family member.

MS. EHRENKRANTZ: I just want to raise a possible integrity issue of if an individual is incompetent to answer, who will speak on behalf of that individual? And may there be pressure on residents by the facilities to make representations that are flattering for the institution?

MS. DAVEY: It goes to their authorized representative (authorized reps).

MS. EHRENKRANTZ: There are issues involved with who are these designated authorized reps?

MS. DAVEY: My understanding is that these satisfaction tools are used globally throughout, nursing home satisfaction tools, so they usually go to the authorized rep of the member.

MS. EHRENKRANTZ: I just want to raise the issue for you when you're doing your assessment to be mindful of who has control of that data.

MS. LIEBMAN: Evelyn Liebman, AARP.

So, a lot of these questions were considered

by the Workgroup, and I think one of the reasons that the Workgroup along with DMAHS chose Dr. Castle is because of his national experience with working literally with nursing home residents and their caregivers and dealing with issues like that where to mail the surveys, exit surveys that are found to be most effective. Those were issues that were considered and propped up the decision.

MS. OTTERBOURG: I mean, he's really -- he's national leader, renown really for his work in this field, so I just echo what you said.

MS. LIEBMAN: I just want to make another comment. DMAHS, the Division of Aging Services (DoAS), the Department of Human Services, and DOH are all stakeholders on this, it really is a big step forward in terms of the evolution of MLTSS. These folks were called. One of the theories, if you will, behind MLTSS is that there would be an opportunity for MCOs to use quality and cost in developing their networks. And so this begins to move us in that direction. And once the designations are in place, it will allow MCOs to not contract, if you will, with those who do not get an Any Willing Qualified Provider (AWQP) designation. But I think that for those or the Workgroup, we were also very careful in terms of looking at the data that

exists now to ensure that we also have some minimal level of network adequacy over this period of time and give facilities an opportunity to correct whatever deficiencies that may be out there. We didn't want to leave any county without an AWQP designated facility. Obviously, we'd like more than one or two. But also, I think it's so important that the information is going to be publicly available. It will be transparent on the website. And, residents and their families will be able to access the information and make a choice themselves as to whether or not they want to stay in a particular facility.

DR. SPITALNIK: I just would like to thank Evelyn for that and also really to sort of trace the history of the intensive work that was done on quality measures with the first comprehensive waiver. So, it's very gratifying to see that this is going to have real impact on people's lives.

Wayne.

MR. VIVIAN: I think that it's really important you're doing this; it's really great.

Eventually will this be the standard, licensing standard that every nursing provider and nursing home provider must achieve this credential or this level of guarantee of service? Because I could

see this starting out here, but then eventually that this is a requirement that you have to have this, that they all should have this.

MS. OTTERBOURG: It's a requirement for nursing homes that are participating in MLTSS. So, it will be a requirement. I mean, Nursing Home Compare, is what you can see, for example, how XYZ Nursing Home is doing. This AWQP designation is looking at measures that we've chosen specifically with regards to the MLTSS program. So, if you're a private pay nursing home resident in New Jersey, you could see how the nursing home that you're staying in is fairing, no matter how it ranks.

Part of the work around this, there are -- and I'm not going to get into the details of all this, but just to give you an idea, let's say you're in a nursing home and your spouse then needs to go into a nursing home. And the nursing home that you're in is all of a sudden not meeting AWQP designation status. But that might be an exception that we would grant because the spouse wants to join the wife in the nursing home that doesn't meet the designation. So there are going to be exceptions, but that's the basic idea.

MR. VIVIAN: Very good.

DR. SPITALNIK: But beyond that, and this is, I think, a broad community advocacy issue. Does this also initiate a dialog with the Department of Health in their role in licensing nursing homes to incorporate this standard?

MS. OTTERBOURG: Well, we work with them on a lot of these advocacy issues. You're absolutely right. And that's why they've been a partner from the beginning with this initiative.

DR. SPITALNIK: Thank you.

Phil.

MR. LUBITZ: I just want to comment. DOH publishes inspection reports on their nursing homes.

DR. SPITALNIK: Thank you.

Other comments?

Laura, thank you so much. And it's so exciting to hear.

So this is the point in the agenda where finish the formal presentations and we do some stocktaking to look at what we anticipate or we'd like to see on the agenda for our next meeting, which is here and is on Thursday, October 19, 2017.

Certainly, an update on the national situation with Medicaid. The other items that I have are a presentation on the Comprehensive Medicaid Waiver

renewal (CMW Renewal) approval.

There were concerns raised about LogistiCare, so we'd like a presentation on the requirements in the RFP that resulted in the award of the contract.

We also discussed a presentation on the child quality measures. The issue was raised, as it has been in the past, what are the DDD appeal processes for services funded under Medicaid. And for our 2019 meeting, the first annual report that Laura just gave.

Are there any other agenda items from the MAAC?

Beverly.

MS. ROBERTS: I'd like to see if we can have an update on the DDD dual diagnosis project, what's happening with that.

DR. SPITALNIK: Okay. Thank you. We will add that.

Other items?

MS. ORLOWSKI: Real quick. On CMW Renewal presentation, if there could also be a part of that addresses the short-term nursing facility stay provision of the waiver and how to access it. I don't think that's changing, but it's something in the current waiver that's really difficult to find for

clients.

DR. SPITALNIK: Thank you so much for that.

I would ask that, if you haven't already, to sign in. The presentations that were presented today, those slide decks are posted on the DMAHS website at: http://www.state.nj.us/humanservices/dmahs/boards/maac/. Give us one day at least to post them.

And, then I am seeking a motion to adjourn.

Mary Coogan.

Second, Sherl Brand.

We are adjourned. Best wishes for a good, safe, and healthy summer. And we'll see you October. And, thank you so much to DMAHS and to all the presenters.

(Meeting concluded at 12:37 p.m.)

CERTIFICATION

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

_____

Lisa C. Bradley, CCR

The Scribe