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

February 5, 2020
10:09 A.M.

FINAL
MEETING SUMMARY

Members Present:
Deborah Spitalnik, PhD, Chair
Theresa Edelstein
Beverly Roberts
Wayne Vivian
Mary Coogan

State Representatives:

Jennifer Langer Jacobs, Assistant Commissioner

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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/.

CHAIRWOMAN SPITALNIK: Good morning. I'm Deborah Spitalnik, and I'm delighted to welcome you to the February 5th meeting of the New Jersey Medical Assistance Advisory Committee. We thank you all for your flexibility and understanding that we needed to change the date of the meeting.

This meeting has been advertised in accordance with the New Jersey Open Public Meetings Act. The other thing that I need to announce as guests of this State Police barracks here, I'm required to let you know that in the case of the emergency to exit out of the rear of the auditorium and then pass the security desk and gather at Parking Lot Station 9. I'm sure we won't have an emergency, but I'm obligated to tell you that.

Our process as a committee has been to both welcome, in accordance with the rules and spirit of Medicaid, the input of the public. But we do maintain a structure where if there are questions or comments about presentations or information, that the members of the MAAC have the opportunity to ask questions first. I would then call on members of the public, asking you to stand, if you can, state your name very clearly for the purpose of our recorder, and to ask a brief question. We have prided ourselves as a working group that we've never had to isolate

public input to a confined period at the end of the meeting, but rather have a robust dialog. But if that got burdensome, we'd have to resort to that, so I count on our shared spirit to not do that.

So what we will do now is I will ask the members of the MAAC to introduce themselves. I'll then turn to all of you to ask you to just use this as an opportunity to identify yourself and your connection or organizational affiliation, and then we will proceed to our agenda which includes approval of minutes, some eligibility and enrollment updates, a public health update, a set of managed care updates, and then some initiatives that are in the planning and implementation stage. So welcome, everyone.

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(Members of the MAAC introduce themselves.)

(Members of the public introduce themselves.)

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CHAIRWOMAN SPITALNIK: Thank you, all. And welcome, everyone. There are seats in the front. Please feel free to come forward.

With that we will now turn to the approval of the minutes. Under consideration are the July 25, 2019, minutes. I believe we have a quorum, and we can look at the summary.

Are there any comments, corrections, questions

from the MAAC?

Hearing none, do I have a motion for approval?

MS. COOGAN: So moved.

CHAIRWOMAN SPITALNIK: Coogan.

MS. ROBERTS: Second.

CHAIRWOMAN SPITALNIK: Roberts, second.

All those in favor?

THE MAAC MEMBERS: Aye.

CHAIRWOMAN SPITALNIK: Opposed?

The minutes are approved. Again, always with our thanks to Lisa Bradley for documenting our work.

We now turn to eligibility and enrollment updates. Jennifer Jacobs, Assistant Commissioner and Director of the Division of Medical Health Services, is going to speak with us about performance standards for S. 499, the legislation to provide for approved system for eligibility determination.

MS. JACOBS: Thank you. Well, it's good to see you all this morning, and I thank you for being here.

This topic is in response to some questions we received at the last MAAC, and we are trying to give you a really clear sense of how we're implementing this legislation. Just to give folks a little bit of a summary, if you haven't been as focused on S. 499 as some of the rest of us have been, this is the legislation that came to us and

said, in a world where Amazon knows where our packages are every minute, we should have a better sense of our progress on Medicaid eligibility and we should have better reporting on those processes. So we took that letter in spirit, and we have been working on the implementation around it. So I'll give you a little bit more information today than we had the last time. And then you'll see a few pieces that are still under construction.

(Slide presentation by Ms. Jacobs.)

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

CHAIRWOMAN SPITALNIK: Thank you.

Does anyone on the MAAC have any questions?

Bev Roberts.

MS. ROBERTS: Good morning. And thank you very much for this information.

Just a comment on the initial application timing processing slide. So you know we have folks that are DACs and where they've had SSI and Medicaid and then they start to get SSDI, usually because of mom or dad retire or become disabled, passing away. So those are folks that are applying to the county for the first time, but they previously had Medicaid because they had SSI Medicaid

package. So they've already been determined eligible, et cetera, and I just wanted to throw it out there that although these are new applications, to me, it should be like a redetermination because it should pretty much sail through quickly just looking at the bank account information for ABD. So I just sort of wanted to mention that.

MS. JACOBS: Thank you.

CHAIRWOMAN SPITALNIK: Any other questions from the MAAC?

Yes? And please tell us your name.

MS. MARINARO: Lauren Marinaro, Fink Rosner Ershow-Levenberg.

We are having a lot of concerns about -- I refer to them as premature denials due to documentation. There is specific language in S. 499 related to how these time frames should not have an ill effect on the applicant's ability to have appropriate extensions to get documentation. And I wanted to know what procedures are in place now to properly document and allow applicants to request extensions, be approved for extensions, and get the extensions they need to get the documents in in an appropriate fashion pursuant to the legislation.

MS. JACOBS: I'll give you a brief answer, and then Heidi can jump in if you want. Lauren, right? Thank you for raising that question.

We actually had that issue come up recently and followed up on it to sort of drill down to what happened in that case and why did that happen.

We have explained to the counties that it's our expectation, and I think they agree, that reasonable time is provided. And we're building into the system a way of really clearly tracking when additional time is needed for a case to follow up. For example, the member is pulling together some information that they didn't have readily available but they're clearly in contact with the county as they're doing that. Our intention is to be exactly that, flexible as needed. We can't do that for every single case. There is an expectation that we will stick to the time lines that the federal government has established, but we can create within our system a way of tracking those cases so that the counties know and we know these are the ones that need extra time and we're not penalizing them for providing them.

CHAIRWOMAN SPITALNIK: Thank you.

Gwen.

MS. ORLOWSKI: Hi. Gwen Orlowski, DRNJ. Thank you very much for this. I have a couple of brief comments. I don't know if it rises to the level of a question.

First of all, I'm going to dovetail off of what

Bev said because I completely agree that those cases are really redeterminations, not new applications. And that ties into something that I wanted to ask about. Whether or not this system and training that goes along with it, which we very much appreciate, will provide that training to make sure that individuals are screened for -- I know I'm a broken record on this -- all Medicaid programs before there is either a determination of ineligibility in the redeterminations, and will you be able to track that in this new data system? Because that would be great data to have and I think could also help solve some of the problems that are going on with those redeterminations.

And the second point was dovetailing of what Lauren said about the 45-day federal time period or -- is it 60 or 90 -- depending on whether it's a person with a disability or an older adult or another person. I would ask is there going to be a way in the data mining system to look at people who were denied, appealed, and were successful in that appeal? In other words, that denial, for lack of documentation, was premature because the person ultimately proved that they were eligibility, like, a way to look at that in your system so that you're not denying people for lack of documentation and seeing on the other side of it that the whole time they were eligibility and it was really a difficulty in getting that documentation.

MS. JACOBS: Gwen, thank you for that question. Heidi is actually going to following up the transition between eligibility types, so give us a minute on that. And duly noted on the other points. Thanks very much.

CHAIRWOMAN SPITALNIK: Yes?

MS. SICLARI: Hi. Ryann Siclari of Central Jersey Legal Services. I, again, share the same concerns that Lauren has. I've had multi counties specific tell me they are not permitted to grant any extensions for any reason, period, end of story. So my question for you is if we need to contact a customer service liaison to point these issues out, who do we contact?

MS. SMITH: Heidi Smith from Medicaid.

So we have county liaisons. That has not changed. So we have our liaisons and we have a list and we have their phone numbers.

MS. SICLARI: So that's not something that's been added from the bill? We're using an existing system to address these things?

MS. SMITH: For our ADDD, yes.

MS. SICLARI: And where do we find that information?

MS. SMITH: We have a list. We'll have to just get it out to you. Maybe when we send out the minutes.

MS. JACOBS: The county liaisons are for

members, for advocates, or for both?

MS. SMITH: Yes. Any issues that are going on with any kind of county cases, we have county liaisons that work in the Division and they help work through those issues.

CHAIRWOMAN SPITALNIK: Can I make the suggestion that they be posted on the website?

MS. SMITH: Yes.

CHAIRWOMAN SPITALNIK: Josh.

MR. SPIELBERG: First of all, thank you, Jen, for the presentation and for taking this issue very seriously. I want to just echo some of the comments that have been made before. In the legislation, one of the pieces to evaluate the entities doing determination is accuracy of the determination. And I think that if you get too concerned about speed and don't deal with accuracy, that's going to be a problem for recipients, both in terms of people being denied prematurely, people being terminated or denied without being screened for other programs, and just being denied or terminated for the wrong reasons. So I think it's important to work that into the system and to include in the incentives rewards and penalties for accuracy or inaccuracy determination.

The other thing I would say is you've been talking about counties and their performance. I think the bill also requires an evaluation of the State eligibility

vendor. And could you speak about that also?

MS. SMITH: So they will be using the system, too. They will be using the system, too, the vendor. We'll be using the system also. So their information, their data, will be in there also and captured the same way. It will not be incentivize. They're not part of the incentive program.

MR. SPIELBERG: Because?

MS. SMITH: They are a contracted vendor so they already have a flat rate that they're paid to do this work and do it right and do it accurately.

So this incentive program also was one of those mandates without funding, so we are using our existing dollars that we have in the past and we are just reshaping them for this program.

MR. SPIELBERG: Will you be able to incorporate accuracy into the metrics?

MS. JACOBS: Josh, I've made a note of that. As we discussed, having standardized data is what's really critical. But just as on the points that Gwen mentioned, I've noted it and we'll follow up.

CHAIRWOMAN SPITALNIK: Thank you.

Yes, in the back, please.

MS. CROWLEY: My name Roxanne Crowley from the Rothkoff Law Group.

As a client advocate, one of the best ways we have to review the processes of the Boards of Social Services is reviewing files before fair hearing. As everything is migrated electrically, including notations you discussed regarding Lauren's question, tracking cases and not penalizing counties for providing extra time, how are we going to access that information?

MS. SMITH: So how do you get files right now when you want to review them?

MS. CROWLEY: We contact the Boards of Social Services. Depending on the county, they may or may not let us see some of the documents. My concern is that it's going to be even more difficult once it's electronic.

MS. SMITH: Okay. So the information, the file, the application is all in the system. It's all printable. It's all available. I'm not clear -- somebody actually hands you a file?

MS. CROWLEY: Presently, yes.

MS. SMITH: So that information is still available. It doesn't go away.

MS. CROWLEY: So that will all be printed out and available to advocates from your file.

MS. JACOBS: Heidi, I think that's work-in-progress. We'll follow up with you on that.

CHAIRWOMAN SPITALNIK: Thank you.

Yes, John.

MR. KERN: John Kern. A question in terms of the Department's thoughts about the publication or ready availability of aggregate county performance, and is there sort of an idea that they're going to make that sort of an OPRA information or you're going to actually actively publish that?

MS. JACOBS: Thank you for reminding me to talk about something I forgot, which is the bill requires us to put -- I can't remember the exact wording out there, but to have public reporting. I think of it as scoreboards onto our website, and so we aim to do that as soon as possible.

CHAIRWOMAN SPITALNIK: Thank you.

Other questions?

Thank you so much. We move on to two presentations from Heidi Smith who is Chief of Operations; the first being New Jersey FamilyCare enrollment highlights.

Welcome to the podium, Heidi.

MS. SMITH: Good morning. So I'm here to talk about the NJ FamilyCare enrollment highlights. So in focusing on the highlights, there is no highlight on this slide because you'll see that the enrollment has pretty much changed. It's been a net decrease of .01 in change, and our families are enrolled in Managed Care.

(Slide presentation by Ms. Smith.)

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CHAIRWOMAN SPITALNIK: Let me just stop you for a second. Are there any questions from the MAAC about enrollment?

Thank you. I just wanted to make sure we addressed anything. Please go on to transition.

MS. SMITH: Okay. This slide here is about what we are already doing with SSI. I thank you for all the advocates in the community who make sure that stay on our toes and we're doing everything that we are supposed to do. We want to get it right. We want to do this correctly.

(Slide presentation by Ms. Smith.)

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CHAIRWOMAN SPITALNIK: Thank you. Questions or comments from the MAAC?

Beverly.

MS. ROBERTS: Thank you, very much, Heidi.

So with regard to people that have NJ FamilyCare,

and if you're 65 you're going to have Medicare. But a lot of our folks aren't 65 but they have Medicare because they've had SSDI for a couple of years. So I'm just concerned about -- it's great that you are want to check and see with CWA and are they eligible. Great. But let's use a hypothetical of somebody who's got SSDI, they just got Medicare. So now they're not going to be eligible for the NJ FamilyCare anymore. They're not 65, but they've got their Medicare. If their income is over the ABD limit -- let's just say they've got SSDI because a parent had passed away, they've got $1400 a month from SSDI -- they won't be eligible under CWA guidelines. They will be eligibility under that non-DAC process through DDD. And there won't be a lot of them, but, obviously, I hear about a lot of them and I'm concerned about every single one. What will happen so that those folks won't be routed to the CWA that their not eligible and then just told flat, well, you're just not eligible for Medicaid.

MS. SMITH: The people in our system that are DAC, there is not, like, a personal indicator on there. But it is something that we are still working through to improve all the functionality so that we capture every population so we don't have anybody falling out that way.

The ISS system is the last to come into the worker portal. We're not there yet with the supports in PDN or the

CCP Program. That's not yet in the worker portal. That's still a manual paper application. It's on the list to come in so that we can share that more seamlessly.

MS. ROBERTS: So is there some way -- just as an example, if you have people that are 65 or over, that's probably a lot of those folks that are going to lose it because they're 65 and they're getting Medicare. If they're at the younger age, is there some way that it can be tracked, like, oh, this is a person who's 35 years old and they just got Medicare, hmm, let's check with DDD or something to see if this is a person getting DDD services and, therefore, could likely be more non-DAC and not eligible through CWA?

MS. SMITH: We have certain families that have program status codes. We have certain indicators on some of our families that we know which beneficiaries are -- by their programs. We call them program status so we know which program they're in and we how to help transition them to the next program.

CHAIRWOMAN SPITALNIK: Thank you for that.

Jonathan Seifried is Assistant Commission for DDD. We're turning to Kelli Rice from DDD.

Kelli, would you get up and could you respond to that, please?

MS. RICE: Bev, if you want to have a

conversation afterwards maybe we can have a phone call, but I do want to let you know that the people within DDD who work with the eligibility and for the people who are over that threshold but are going on a waiver so they're allowed to go to the institutional limit, we've been working with Heidi and her team and we've already made some changes to the system. I believe Heidi mentioned it at the previous meeting where there's now an indicator on the application that indicates if you have an intellectual developmental disability so that their staff will reach out to our staff to see if they're known to us so that it doesn't get routed to the wrong place, because we did experience some of that. We've been trying to make some corrections to that. So we do have a process in place. We can maybe have an offline conversation and talk a little after the MAAC meeting.

CHAIRWOMAN SPITALNIK: Thank you.

MS. ROBERTS: Terrific. The ABD application, I know that's there. Is that on the regular NJ FamilyCare application as well, the IDD question?

MS. SMITH: The question is only on the ABD application. The NJ FamilyCare, the MAGI application comes with CMS.

MS. ROBERTS: So there is no IDD indicator on that? I'm just talking NJ FamilyCare folks, not the ABD.

MS. SMITH: I'll go back and double-check.

CHAIRWOMAN SPITALNIK: Thank you.

Mary.

MS. COOGAN: I was going to ask, because it seems like a lot of this is new, that maybe we could get a progress report at the next MAAC meeting. It sounds like people are trying to troubleshoot issues and try to fix certain things so that people don't fall through the cracks of the transition, but it might be helpful to get an update as this progresses. Is that okay?

CHAIRWOMAN SPITALNIK: I will note that for the agenda.

Wayne.

MR. VIVIAN: It's my understanding, like wouldn't a person who's transitioning out of Medicaid because they're turning 65, but wouldn't they be dual eligible for Medicaid and Medicare? Because how could you -- you can't get Medicaid unless your income -- if you're 64, your income has to be a certain level for you to be eligible for Medicaid. So your income remains at that level just because you turned 65 and then you get Medicare, you should be dual eligible then.

MS. SMITH: So let me just clarify. Only the expansion population cannot have Medicare with Medicaid. We've always had Medicaid and Medicare all along. But there's a certain population, the expansion population,

this is our higher income single adult who cannot have both Medicare and NJ FamilyCare. So that's the population. And we can tell them apart in our system. We have program status codes to help us send what bucket they're in.

MR. VIVIAN: Could you tell me what the income max is for the eligible for Medicaid with the expansion?

MS. SMITH: So that income just changed in 2020. It's committed in my memory. I know it's up to 138 percent FPL. But what does that look like as a dollar amount --

MR. SPIELBERG: It's about 17,000 a year for a single a person.

MR. VIVIAN: Single person 17,000? Okay. Thank you.

CHAIRWOMAN SPITALNIK: Any more questions from the MAAC?

Yes?

MS. MARINARO: I think my question is actually a partial answer to your question.

CHAIRWOMAN SPITALNIK: Please state your name again.

MS. MARINARO: Lauren Marinaro.

One the reasons people lose eligibility at 65 when they have eligibility under MAGI is that they had assets. And assets are not part of the eligibility criteria for MAGI. I was wondering if potentially you could consider

maybe lengthening the four-month period to longer -- six, eight months, what-have-you -- because there are opportunities to deal with the asset question prior to the age of 65 for certain individuals that might need to transition over. But the minute they turn 65, those opportunities go away. I talk to you about special needs trust, pooled special needs trust, et cetera. So if there is that ability to plan ahead and give that heads-up, four months is not a lot of time to deal with that issue.

MS. SMITH: That's question that we're going to have to talk with CMS about. I mean, four months, telling people in September that they're eligibility looks like it could be ending in December if we don't take some kind of an action. So what we're doing is keeping people on four months after -- they could have 65 in September or got on Medicare in September. We usually find out after the fact that they got on Medicare.

MS. MARINARO: So you're not telling people, like, four months before they turn 65?

MS. SMITH: Sixty-five, we can do that. We're good. Four months, because I can see you're turning 65. But Medicare is a file that come for us. So sometimes families are on Medicare for several months before we know. So when we give them an extra four months, that's our first time to let them know that something different has to happen,

we want to work with you during that time.

MR. VIVIAN: Does anybody know what the asset limit is for the expansion?

MS. SMITH: There is none.

MR. VIVIAN: There's no asset limit? You could be a millionaire?

MS. SMITH: As long as you don't generate income.

MR. VIVIAN: As long as your income is 17,000 or below, you can have a million dollars in assets and still be eligible?

MS. SMITH: Yes.

CHAIRWOMAN SPITALNIK: Thank you.

Gwen.

MS. ORLOWSKI: Hi. Gwen Orlowski, DRNJ.

First of all, I just have to give a huge thank you because I probably have been a little bit of a thorn in your side. I am so appreciative.

MS. SMITH: No, not Gwen.

MS. ORLOWSKI: I've listened, and you're moving this forward. So, you know, I really appreciate it.

MS. SMITH: We want to get it right. It takes a little time, but we want to get it right.

MS. ORLOWSKI: I want to publicly knowledge that.

I have two quick things.

One is as you're doing this, I heard DOAS, which I assume is the Division of Aging Services, I never heard it called DOAS before, but that's good. So in that screen, will you also be screening people for their Medicare savings programs, which are Medicaid programs, paying that Part B, QMB SLMB, QI, that would be really great so that could happen.

MS. SMITH: And I think they were here the October meeting talking about all the programs that they have. Our information to them just helps them to know who else to outreach to.

MS. ORLOWSKI: Okay. We would say they still have to be screened also so that's seamless as well.

And then the other point I had is actually a question. I really appreciate the update on the SSI going to the CWAs and now they're getting their notices for the prepopulated as well as termination notices. One of the things we're hearing is that it's a little bit different for folks who are coded with a DDD code, that that is not going to the CWAs. That's going maybe to Kelli. Could you just address that so we understand where those cases are going?

MS. SMITH: So if these termed if they're coded as DD population, then we send that file to the support coordinators and they outreach. They know. They know the

best address. They send any kind of archived information that we may need out to the families and get the packets back themselves, get that information back and work with the family. And then they get that information over to Brian's unit to process, to look at.

CHAIRWOMAN SPITALNIK: Could you label that, as opposed to Brian?

MS. SMITH: The ISS Unit. I'm sorry. They get that information over to our ISS Unit for them to look at for eligibility or continued eligibility.

CHAIRWOMAN SPITALNIK: Kelli, did you want to add to it?

MS. RICE: The RFI packets are sent out by the DDD staff. I just wanted to clarify that. And then they are returned. They're completed by the guardian and returned directly, as Heidi indicated, ISS.

CHAIRWOMAN SPITALNIK: They didn't hear you.

MS. RICE: The blue packet, the RFI staff, it isn't sent out by the support coordinators. It's actually sent out by DDD staff. That's all the clarification I was making. And then Peggy Guardian, whoever's completing that RFI packet, it is returned. There's a cover letter in there to indicate that it doesn't get returned to the Division of Development Disability, but rather it is returned directly to Medicare staff, specifically ISS staff.

CHAIRWOMAN SPITALNIK: Thank you.

Beverly.

MS. ROBERTS: I just wanted to be clear because I've heard different things at different times. So my current understanding is that it would be the packet for a person who did have SSI now and got the four months' notice. The packet would be mailed out from DDD to the family or the legal guardian. If the person is on Supports, my understanding is it would then go back to the county. If the person is CCP, then it would go back for SSI review. Is that correct or not?

MS. RICE: So if you were on the CPA, the Community Care Program, that RFI packet is going back to Medicaid staff at ISS. If you were on the Supports program, it is going to Dave Powers' unit, which is a different part of Medicaid.

MS. SMITH: But they switch applications all the time. So they come back to the Division. The address is in there. They come back to the Division. Dave's unit processes for Supports. And Brian Brennan processes applications for the ISS. And whichever they need, they're able to just give it to each other.

MS. ROBERTS: So it's not going to the county, then? If you're a Supports person, it isn't going to the county?

MS. SMITH: No. They're return envelope is sending it back -- their return information is sending it back to our Division, because that's where the Supports office and the ISS office are located.

CHAIRWOMAN SPITALNIK: Any other comments or questions?

MS. ORLOWSKI: I just have a follow-up on that. It would helpful if that process would be on the website. I think there's a lot of confusion on that process. If there could be something in writing that we all could all see, like a flowchart or something, it goes here, it goes here, it goes here. We're sitting here and we're still, I think, confused.

MS. SMITH: So in the packet, there is where it gets returned to. That particular packet has return information.

MS. RICE: DDD can create a flowchart and send it over the Medicaid and then have that placed on the website.

CHAIRWOMAN SPITALNIK: Thank you, all.

Any other points before we move on?

Yes? Your name, please?

MR. GRAMER: Bill Gramer. Which website?

CHAIRWOMAN SPITALNIK: I think that's to be determined.

MS. JACOBS: I don't have that answer right now.

CHAIRWOMAN SPITALNIK: Thank you. But we will announce that. And I have noted that this is an issue that we want to pick up the thread with a progress report at our April meeting.

Thank you very much, Heidi.

We're going to move slightly in a different order. The Assistant Commissioner is not yet here from the Department of Health, so we're going to have the public health update later in the agenda.

We're going to move on to Managed Care updates. And I'm going to turn back Jen Jacobs for an update on UnitedHealthcare Community Plan.

MS. JACOBS: Thanks, Deb.

We added this topic to the agenda for today because we had received a number of questions from members of the MAAC and the public. And so I will give you a brief summary of our latest status with UnitedHealthcare Community Plan and then turn to the members of the MAAC for their questions.

I would like to start by saying that at New Jersey FamilyCare within the Division of Medical Assistance and Health Services, we want to serve people the best way possible. And we are increasingly focused on how we do that within the existing contracts we have with our Managed Care

partners and with our vendor partners and the ways that we can draw from best practices around the country to ensure that New Jersey is getting the greatest value possible out of these partnerships that serve our 1.6 million New Jersey FamilyCare members. So when I'm speaking to you about the freeze that we put on UnitedHealthcare's new enrollment, I am speaking to you in that specific context. And I hope that you will find there is consistency between this discussion that I'm having with you now, the discussion that we had a few minutes ago about accountability with our county partners, and discussions that we will have together in months ahead with respect to other partners who do this work with us. And those partnerships are critical, they are collaborative, they need to be accountable, and we should be transparent with you about that. It is my intention to be very clear with you when we take action like this why we took that action.

So you all know that I like to talk off the cuff, and I want to be very interactive with you and I want you to hear me think. In this particular case, I also wanted to make sure that I covered a few specific points. So if you will forgive me, I'm going to refer to some notes as I go.

We decided to freeze United's new enrollment on a temporary basis. That's a statewide freeze that we

imposed and that was agreed to by the leadership of UnitedHealthcare Community Plan.

The purpose of the freeze was to allow them to address some operational issues and some quality issues that had come to the attention of our team, sometimes through our own internal monitoring and other times through the experience that our members were having and that some of you were sharing with us. We want United to focus its attention on these priorities. We've been meeting with them on a biweekly basis formally, and we've had numerous phone conversations in between those biweekly meetings to make sure that everything is on track for the progress that we want to see.

We understand that there will be questions and concerns from members. We can talk through some of that today. And I want to emphasize that we have four alternative plans in nearly all of our counties here in New Jersey. There's one county where there are three alternative plans. But members do have multiple plans to choose from, and each of those plans is contractually bound to serve our members, to coordinate their care, and to ensure they receive the care they need within that health plan's network or, if necessary, outside that health plan's network. It's our job to make sure that happens.

So I want you to understand that this freeze is

part of this new vision and some new performance accountability that you'll see roll out from our agency over months ahead. We're working closely with United. Their leadership has been very collaborative with us on this. And we're working with all of our health plans to be sure that, as I said in the beginning, we are getting the value that we expect from these partners. That is true as well of other partners. Examples would be we talked about the health benefits coordinator earlier. We have had many conversations about our transportation vendor. There are opportunities all over the place here for us to think collaboratively with our vendors and also to look at best practices from other states. So that's what we'll be doing. And I appreciate your continued focus because the information that you share with us is important as we work through some of the examples to understand root cause, to understand where workflow needs to be improved, to understand where operational issues are, and ultimately to make decisions like the one that we made with United.

So this is a temporary freeze. It began November 15th. I cannot give you today an estimate of when we will lift that freeze, but I can assure you that we are meeting with United's leadership on a regular basis. We were looking for corrective action. We are seeing them taking corrective action. And we will keep you updated when

we're able to give you an estimate on the end date of the freeze.

I would like to pause there and take questions.

CHAIRWOMAN SPITALNIK: Thank you so much.

Are there any questions from members of the MAAC?

Beverly.

MS. ROBERTS: Thank you very much, Jen, for this information.

So there have been some rumors with regard to some reductions perhaps in the United network that the State told that MCO that they should be doing that. And I wonder if you could address that.

MS. JACOBS: I can address that to the extent that I have heard the rumor. The state did not direct the health plan to terminate any relationships or reduce their network in any way.

CHAIRWOMAN SPITALNIK: Thank you.

Other questions or comments from MAAC?

Theresa.

MS. EDELSTEIN: Thanks.

One of the issues that we've been dealing with is something you touched on, which is the requirement that other health plans, whether in or out of network, provide the services that enrollees need. I have seen struggles with that particularly for children who are being served by

providers in the southern part of the State. I'm just going to leave it there. And I have shared some of that offline, but I think it's important for us to stay focused because we have to maintain access to care for especially in this case vulnerable children whose parents or guardians or legal representatives don't really understand how to navigate this process when their health plan is not in the game, so to speak.

CHAIRWOMAN SPITALNIK: Thank you.

Wayne.

MR. VIVIAN: To echo on your point, vulnerable metal health consumers also face these issues because a lot of times they get their treatment services from a hospital provider. That hospital doesn't accept that HMO, that Medicaid HMO, and it really disrupts the consumer's total health because they have doctors that are within that network, so they're set up with their doctors. Then all of a sudden, the hospitals stops working with that current HMO, and then they can't see -- they miss their psychiatrist appointment, they miss their medication monitoring appointment. It really can become very disruptive. I mean, I was hoping that there would be some way that people could still get served even if that hospital or whatever no longer works with that HMO. Is there some way that -- because didn't it used to be that if you had Medicaid,

regardless, it didn't matter who you had, you could still get services? But now it seems like hospitals, they don't want to bill outside of the network.

MS. JACOBS: So, Wayne, I would like to look at a couple of cases with you. I find this to be very helpful to us as we're trying to troubleshoot. Sometimes we're troubleshooting a crossover between Fee For Service mental health coverage, which exists for most of our population, and Managed Care medical coverage. We want to be coordinating well. There needs to be a nice bridge there so that we're doing that the best way possible.

On the other hand, if you were describing a disconnect where the member has no mental health behavioral health coverage through their plan, then we would want to see what's going on at the plan internal where something is disconnecting and then maybe there's a third explanation I haven't even thought of. Right? So I'd like to try to use individual cases as learning cases. We're actually doing that with a number of cases right now.

MR. VIVIAN: From my experience, it seems to be the hospitals that become resistant. In other words, they don't want to go outside of their -- I'll call it comfort zone -- but it's their network.

MS. JACOBS: Like a referral network.

MR. VIVIAN: Right. Like, in other words, if

you don't have the HMO that we contracted, that we chose to contract with, we're not going to serve you. And people will show up for their appointment, and they literally will not get served.

MS. JACOBS: Let's walk through the example, and maybe that's good homework for you to give Theresa and me, since Theresa is representing the hospital association and I've got the Medicaid program. Then we can troubleshoot that one together.

MR. VIVIAN: Okay. Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Anything else from members of the MAAC?

Members of the public?

Gwen.

MS. ORLOWSKI: Thank you very much, again, Jen. I have three points and I'm going to borrow from you, doing the third first, which isn't directly on point.

I'm going to mention about Private Duty Nursing, and I want to let you know that we do have a consumer here, a parent of an individual with an intellectual development disability who receives PDN, and I think they're going to want to say something. And I'm looking at your agenda, and I'm not quite sure where it fits in. So if you will want to let me know that while I say the other two this things, that would be helpful for us.

I have two quick points. One is on behalf TRNJ, but several of the advocates have talked about our concerns with respect to this, and we would really appreciate if there could be what I'm going to call an ombudsman function in the Division who could help us troubleshoot in cases where things are happening. I think Bev's example, we've heard the rumor too that suddenly a provider is not in network anymore, somebody may need a specialized neurologist or their Private Duty Nursing provider is no longer in the network and so they're falling off a cliff on Private Duty Nursing. So our first ask is if there could be an ombudsman.

And our second ask is for these critical services like Private Duty Nursing, PCA, that keep people living in the community, as well as certain specialists -- and I think this echoes a little bit also what Theresa said -- if we could think about there being a moratorium on adverse benefit determinations during this period of moratorium of new members until the corrective action things get worked out. We're a little bit concerned about that. We're concerned that people haven't gotten their full due process in reduction cases. We're concerned about the network issues. And we just don't want our most vulnerable people to be without these needed services.

So those are the two concerns I have.

CHAIRWOMAN SPITALNIK: Thank you.

What I would ask is that we raise the Private Duty Nursing issue after the update on Managed Long Term Services and Supports where it fits service-wise. Thank you.

MS. JACOBS: You said for certain services could we have a moratorium on adverse benefit determinations because of concerns about due process. And what I would say to you there is I would not take anything off the table. I would not take that action right now because we brought this to United's attention. We asked them to put corrective actions in place immediately. We said we need you to train and retrain staff on the operational issues we've identified. They have been taking those steps very collaboratively. If we continued to see a pattern, if we saw a troubling pattern, I would not take any such action off the table.

With respect to the ombudsman opportunity, I think that's a really good suggestion. I appreciate it. I think of this as a Medicaid community; I always have. And we don't want anyone falling off a cliff on our watch. Right? So if there's something that we can do as community to make sure that this goes as smoothly as possible for people, we should. And putting an ombudsman in place for this temporary period, I think, makes a lot of sense.

The way I would approach that, as I think it through, there are systems of record that people in my office

don't use that are in use at our health benefits coordinator. And those systems of record are very important for tracking interaction with our members and for acknowledging their requests, for making a plan change, for example, for helping them look at what their options might be, what networks is my doc in. That's system is not something that's in use at my office. We need our members calling the health benefits coordinator, the New Jersey FamilyCare hotline.

But for this community, if we're seeing issues pop, I would like you to have access to the folks in my office so that we're having that conversation, we're not waiting to kind of hear about trends from our hotline, but actually kind of getting that information in real-time. So I would ask you to make sure that our members are calling the hotline because that's where we have those critical tools that enable us to track our communication with them and to honor their requests. We don't have that software in my office.

But we can absolutely put an ombudsman in place for the folks in this community who might be seeing trends, representing multiple members, letting us know things because you're a little bit more informed than the average consumer and you can share stuff with us right away. That would be very helpful to us. So we'll go ahead put that in place. I don't have a name for you in this moment, but if you call the Deputy Director's office and you request to

speak to the United liaison, we can have someone who we will train up and have available for that purpose.

CHAIRWOMAN SPITALNIK: Thank you.

Any other comments at this point?

Thank you so much.

We'll now move to contract changes. Carol Grant, Deputy Director of DMAHS.

Welcome, Carol.

MS. GRANT: Thank you.

I'm going to give you highlights of the January 2020 Managed Care contract. You should know that although CMS has not yet fully executed the contract or signed off on the contract, that approval is expected in the very near future, but we don't expect any major changes. So when I talk about what we have included in the January 2020 contract, I feel pretty confident that that's exactly what will be in the final. And once CMS signs off, then the contract will be posted as it normally is.

(Slide 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/.)

CHAIRWOMAN SPITALNIK: Carol, I'm always appreciative of how you can reduce this complexity to

clarity.

Are there comments or questions from members of the MAAC?

Bev.

MS. ROBERTS: Thank you so much, Carol.

A couple of questions. And this could just be my lack of understanding here. But in that first bullet, the new definitions community based care management, the orthodontic treatment, dental, et cetera, do we know what those new definitions are.

MS. GRANT: We would have to get back to you on the specifics, but they're targeted to be clearer and more easily implemented. We constantly are monitoring program performance and adding improvements. I would have to get back to you on details.

CHAIRWOMAN SPITALNIK: I will note that as an agenda item.

MS. ROBERTS: Okay, great.

What is centering? You said it's been added. I just don't know what it is.

MS. JACOBS: It's group counseling sessions for pregnant women.

MS. ROBERTS: That's good.

So the addition of requiring the MCOs to monitor automatic prescription drug refills, what is connected to

that?

MS. GRANT: Well, we want to make sure that this is done with member consent and that we're not having a lot of unnecessary prescription refills. So we're wanting people to pay attention to that. I'm sure it happens in our own lives. Very often they're filling a prescription, then the prescription gets changed. It's not efficient and it's not even particularly safe.

MS. ROBERTS: That makes sense.

The orthodontic treatment services section, has there been a change?

MS. GRANT: I believe that each year in every contract -- as matter fact, probably every six months we see -- we probably moved it to appendix B, but we're always tightening requirements, clarifying requirements, and that's basically what we've done here.

MS. ROBERTS: Is there restrictions that weren't there before?

MS. GRANT: I don't know that we're always including restrictions. I mean, that may be true sometimes. I think what we're trying to do is to be very clear about what the benefit is and to assure that the benefit is delivered as we expect it to be. I think you'd have to read it and kind of see for yourself.

MS. ROBERTS: Thank you. Thanks very much.

CHAIRWOMAN SPITALNIK: Are there other comments or question?

Wayne and then Theresa.

MR. VIVIAN: Regarding dental treatment, I mean, dental access and treatment was limited under Fee For Service for Medicaid recipients. Is there any concern that under Managed Care will be more limited, what people will have access to and what treatment they will get? I assume everything will be monitored closely as to what --

MS. GRANT: The dental benefit has been expanded because we used to offer dental benefit up to age 12 and then to 19. Now it's a full dental benefit and it has been in Managed Care and it has, in fact, been managed well. There are times we report the number of even grievances appeals around dental. So we monitor it very, very carefully.

MR. VIVIAN: Have you added more dentists to the -- have more dentists been added to access?

MS. GRANT: Of course, there are network adequacy requirements. Recently -- and I probably call it always the wrong name -- Council on Developmental Disabilities actually did a forum around dental access for individuals with development disabilities and other intellectual developmental disabilities around the very issues of access and expanding capacity. I think we're looking at oral health as an integral part of an integrated

care vision that we have. So oral health is extremely important. And I think if we see issues, especially issues of access, we would want to know about them and lead them into our considerations and strategies for really improving just access of capacity overall across the whole Medicaid population.

MR. VIVIAN: Okay, great. Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Theresa.

MS. EDELSTEIN: Carol, thank you. I have a question on your last bullet.

Can you clarify whether the requirement to use Milliman is a requirement to exclusively use Milliman, or are health plans still going to be permitted to also have their own proprietary criteria on top of Milliman, which is what we experience currently?

MS. GRANT: It has to be substantial equivalent to Milliman.

MS. EDELSTEIN: And that's all that they can use?

MS. GRANT: Yes. And it has to be consistent across the board.

MS. JACOBS: Substantially equivalent to.

CHAIRWOMAN SPITALNIK: Do you want to clarify that?

MS. JACOBS: Just emphasize that wording.

MS. EDELSTEIN: So my comment, therefore, is that the tweaks that are made but still fall within the realm of substantially equivalent are sometimes not transparent.

MS. GRANT: Okay.

MS. JACOBS: Okay.

CHAIRWOMAN SPITALNIK: Anything else from the MAAC?

From the public?

Yes, back in the middle, please. Stand up and your name, please.

MS. BROWN: I'm Judy Brown from Gloucester County Social Services. One of my questions, I see a lot of pregnant women and I'm wondering how they would access that.

And the second thing would be we see people that are being thrown off of SSI that the children have autism spectrum disorder. How can we help them access these programs?

MS. GRANT: You know what? I'm not sure I got the second part of your question.

MS. JACOBS: How can we help people access the program?

MS. BROWN: It's mostly access, accessing the programs that are available in Managed Care but they're

really not able to access it. How do they ask the doctors? I think the doctors aren't aware of the services that are available to them.

MS. GRANT: Are you talking about the full gamut of the Medicaid benefit?

MS. BROWN: Yeah.

MS. GRANT: In general, individuals in Managed Care often have care managers that can assist. So if individuals are enrolled in a Managed Care, they are assigned a care manager.

MS. BROWN: So they have to ask for one?

MS. GRANT: Well, the thing is that -- normally, what happens is if somebody comes into Managed Care and they're not part of a cohort that actually is required to have Managed Care, individuals with developmental and other intellectual disabilities, our fully integrated dual eligible Medicare-Medicaid population and our Managed Long Term Services and Supports would be required to have care management. As people come into Managed Care, they are assessed and screened, so you don't have to be part of a special population. If your needs rise to the level of care management, they would have it. They can call through to their managed care companies to member services if they don't have a care manager, and they can help them walk them through access to benefits. They can call. I mean, the

contract generally -- and I don't know, not everybody sophisticated enough to go online, but I think our advocates can help people also by understanding what their benefit is and working with Managed Care to access those benefits that they need.

CHAIRWOMAN SPITALNIK: Jen.

MS. JACOBS: And I would just add to that on my recurring theme that this is a community and an ongoing theme around building bridges of understanding, which I hope to talk more about in months to come, we want to make sure that we're sharing this information across all of these organizations that are represented here because word of mouth is so important in helping people understand what might be available as they are interacting with others who are a part of their micro-communities. So we want to be sharing with you as much as possible, as early as possible, so that you're getting a sense of how things look as we're developing them and then make materials available to you that are consumer friendly so that you can help us make this information available to people. So part of an ongoing theme for this year will be making sure that we're making those materials available to our consumers wherever they are. And Phyllis has done a great job over time of making sure that our MAAC website is much more up to date than maybe some other State websites you've run into. So we try to

always make sure that we're posting the MAAC materials to our site so that you can then use them as public materials, but we want to do as we go forward.

MS. GRANT: And you are very valuable partners in this. Additionally, our Managed Care companies provide a member handbook that can be shared in addition to website information.

MS. BROWN: We've actually never seen one.

MS. JACOBS: I Google them regularly. Often when I'm out and about and I get questions from people, we'll just Google that Managed Care Member Handbook. They're all available, and they do provide the information in a way that is easily accessible to a reader who is not as familiar as this group.

MS. GRANT: They're available both in hard copy if people want them or online.

CHAIRWOMAN SPITALNIK: Thank you.

Other comments or questions?

Yes?

MS. ADAMS: Hannah Adams, I'm an autism provider.

So regarding the requirement to collaborate or services with CSOC, how is that going to be determined as far as, you know, there's going to be the therapy part that's going to be provided through the MCOs and then there'd the

respite and the home care piece that's going be through CSOC. As far as determining what each member should be getting of one versus the other and how much of each, is that something that gets determined by providers, through Medicaid? Like, how is that collaboration going to work?

CHAIRWOMAN SPITALNIK: Thank you for that question, but I'm going to table that until we have the update on the autism benefit. Thank you for bringing it to us.

Josh.

MR. SPIELBERG: Just for clarification, the question about having a care manager, can any Medicaid beneficiary who feels that they need a care manager for assistance request one from the MCO and get a care manager?

MS. GRANT: It's kind of a tough question. In general, usually we're evaluating whether people actually can use a care manager through a screening process. I don't know that we require that this is the case, but I can't imagine that plans would not take that under consideration if, in fact, the need was there.

CHAIRWOMAN SPITALNIK: May I add that to the agenda for next time and seek some clarity about that?

Thank you for the question.

Other questions or comments?

Carol, thank you.

And in perfect timing, I'm delighted to welcome Henry Paul who is the Office of the Assistant Commissioner, New Jersey Department of Health, to give us a public health update on Coronavirus.

Thank you very much for being with us. Just so you know our process, after you make your remarks, I'll ask members of the Medical Assistance Advisory Committee if they have questions or comments; I'll then open it up to the public. Thank you so much for being with us.

MR. PAUL: Good morning, everybody.

So I'm Henry Paul from the Department of Health. I'm in the Office of the Assistant Commissioner for Public Health Infrastructure Laboratories and Emergency Preparedness, PHILEP. Assistant Commissioner Neuwirth is the commander for the Department's novel coronavirus response team, and he apologizes for not being able to be here today. There's, as you can imagine, a flurry of activity going on and we're pulled in a handful of different directions.

I want to take the opportunity today to give you a briefing on the novel coronavirus and the current response activities happening in the State, recognizing that maybe some of this information may not be a hundred percent applicable, but I also want to give you the opportunity to ask a few questions and, most importantly, want to give you

additional Department resources where you can go to find more information should you have specific questions.

So what is coronavirus? Coronaviruses are a large family of viruses found both in animals and in humans. Some infect people. And I'm not an epidemiologist or a clinician, so forgive me if this is redundant to some of you in the room. But they cause a variety of illnesses, ranging from the common cold to more severe diseases such as the Middle East Respiratory Syndrome, MERS, or SARS.

In general, clinicians have a lot of experience managing and treating coronaviruses. I believe there are currently three or four strains in the US right now that are being managed. And just when we talk about the overall profile of 2019 novel coronavirus, NCOV, compared to a lot of other viruses and diseases, when you put the numbers in comparison to each other, the flu causes a lot more deaths and infects -- I think there's apparently about 20 million who contracted the influenza this year.

On the numbers for coronavirus, as of 9 a.m. this morning, globally there are 24,554 cases confirmed, 24,363 or well over 95 percent of those cases are in mainland China. Twenty-five other countries in the world have confirmed cases, with a total 153 confirmed cases outside of mainland China. Of those, 11 of them are in the United States. New Jersey does not any confirmed cases nor does it have any

persons under investigation or suspected cases. There was one person about a week ago who was a suspected case, and their test came back negative from the CDC, Center for Disease Control and Prevention. So that's the stats.

Generally, what we're saying is that preventative health measures should be followed as they would for any other respiratory infection during flu season. Wash your hands, cover your mouth, cough into your arm; if you're sick, stay home. All of this information is on the Department of Health's website. We have a dedicated web page for the novel coronavirus that has our guidance that is updated quite regularly as more information comes out. And I'll provide that link. I can give it now, but I can also follow up with an e-mail if you guys have a better mechanism for sending information.

CHAIRWOMAN SPITALNIK: Thank you. And we will post it along with the afternoon posting we do of our slides. So thank you. But if you'd like to offer it now, that would be appreciated.

MR. PAUL: So the website, if you just go to the DOH website, which is --

MS. JOHNSON: Nj.gov/health/topics/ncov. If you want to New Jersey Department of Health coronavirus, it will pop up. We will definitely put it through. And we'll get you the CDC website as well.

CHAIRWOMAN SPITALNIK: Thank you very much, Dana.

MR. PAUL: This is colleague Dana Johnson. She's the Director of the Office Disaster Resilience, up here in the front.

In addition to the website, we also have two means of getting answers to questions that you may have or for either yourselves or the general public. The first is the DOH just partnered with NJPIES, the poison control, and have set up a 25-hour hotline to have answers to all questions that you may have. So that number is 1-800-222-1222. And, again, I'll send that information out.

CHAIRWOMAN SPITALNIK: Thank you.

MR. PAUL: And then we also have a public facing e-mail address which is ncov@doh.nj.gov. And any question you have will be answered by a subject matter expert with a personalized response or it will provide you with existing guidance that we have that answers that question.

With regard to -- without knowing a ton about the backgrounds of everybody in the room, I had a very brief opportunity to speak with one of your colleagues outside. And I think one area that we are working on and identifying as an area of real importance is combatting stigma and discrimination against the Asian-American population.

We've seen this start to emerge in public schools. There's a lot of misinformation floating around out there. So that is something that we do not have -- that is developed on right now, but we are actively working to develop guidance and make sure that that is something that is really addressed front and center.

With that, I would like to open it up to questions. I can speak to a few more things if anybody would like, but I really want to have the opportunity to answer questions.

CHAIRWOMAN SPITALNIK: Thank you so. Thank you both for being with us. It's a very broad community here, and we're appreciative of the information.

Any questions or comments from members of the MAAC?

Hearing none, any questions or comments from stakeholders?

MS. LAFER: Kitty Lafer, Burlington County Board of Social Services.

The cases that are in the US, because it's a virus, I'm assuming it's antibiotic resistant. How is it being treated in the US?

MR. PAUL: So the question for those who couldn't hear was because it's a virus, it's resistant to antibiotics so how is it being treated?

And, again, I'm not a clinician, so I'll be able to answer with some talking points that I have from our clinicians on staff, but I would refer you to the DOH website and the CDC website. So there's not currently a vaccine that is in development. So like with the common flu that did develop a vaccine as more information about the strain comes out, so that is in the process. This is currently being treated like any other upper respiratory illness. And this is something that health care facilities across the US and in New Jersey are very well prepared for. We deal with a large number of influenza cases and other respiratory infections every day throughout the year. And our guidance is very much consistent with what we had had our medicals professionals trained to deal with.

With regard to specific precautions that clinicians are taking, again, I'm not a clinician, so don't hold me to the fire, but there are both droplet and airborne precautions being taken. So for droplet, that means eyewear and gloves; and airborne is masks. And those are all -- that information is all being communicated and has been communicated to health care professionals in the State. And also, just as another reference point with regard to the treatment and care of these individuals, tomorrow we are holding a meeting with all acute care facilities in the State in coordination with the New Jersey Hospital Association to

make sure that every acute care facility is on the same page and implementing the same correct paths.

MS. JOHNSON: And on the website that we will share out with you, there's a section that says for health care providers, and there's guidance on all of that stuff in that box. The website is very easy to navigate. It's broken out by travel, health care, schools, so you'll be able to find things very easily on there. So that's the most up-to-date guidance to follow.

CHAIRWOMAN SPITALNIK: Thank you. We are very appreciative of your taking time from the work that you're doing to be with us today. And we will communicate on the DMAHS website the links. Our thanks to you and your colleagues for everything you're doing to keep New Jersians well. Thank you.

MR. PAUL: As a closing, I just want to reiterate in a situation like this, the most important thing we can do is keep calm and remember how we operate 99.99 percent of the time, which is we wash our hands, we cover our mouths, we take adequate public health precautions in our day-to-day lives. The biggest threat to a good response is mismanaged expectation. So we appreciate everybody's commitment to keeping a calm head about them and really looking for factual evidence-based information, which is what we at the Department of Health are trying to promote.

CHAIRWOMAN SPITALNIK: Thank you. And please extend our thanks to your colleagues and the Commissioner.

We will now move to update on Managed Long Term Services and Supports, and we welcome back Ms. Brennan, who is Assistant Director of the Division of Aging Services.

MS. BRENNAN: Good afternoon. Thank you.

These are the data updates on Managed Long Term Services and Supports.

(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/.)

CHAIRWOMAN SPITALNIK: Thank you very much.

Comments or questions?

Beverly.

MS. ROBERTS: Thank you so much.

I know that you didn't do Private Duty Nursing data this time. What I'm wondering for of the next meeting if we can deeper dive into Private Duty Nursing as it exists within MLTSS. But also, there are some people under EPSDT who are getting Private Duty Nursing. So I think it would be helpful to know what's happening with persons with IDD that are getting Private Duty Nursing, maybe not exclusively, but that's a lot of what I think the concern

is. And I'd like to see trends. I'd like to just see what's happening. As I said, a deeper dive into Private Duty Nursing would be great.

There's another issue that I think I've mentioned but I think it would be good perhaps to bring up next time as well. That's folks who are approved for Private Duty Nursing, probably through MLTSS. Could be PDN Plus Supports but they've got their private -- oh, and PDN Plus Supports as part of PDN.

So the issue of people who get approved for a certain number of hours of a day and one family in particular, but I know there are other involved, who would like to have flexibility to use those hours in the course of a week, not to ever exceed the daily total of what they're allowed, but because of situations perhaps with the parents, their own health, whatever it may be. One family in particular was given this flexibility in the past so that they could have a weekly total and then decide day by day how much they needed. And now they've been told absolutely not, it must be this amount per day, you cannot go over on any other day no matter what. That's a concern.

And then another piece -- and I know the nursing facility level of care issue is required for eligibility for MLTSS except for my population of younger people. There are folks who would absolutely meet that level. They don't need

Private Duty Nursing, but they need total care which if they were an older person they could certainly qualify for nursing facility level of care. But if they're in a family that's more middle income, they don't qualify for Medicaid. So these are folks who -- and by the way, in New York and Pennsylvania, they probably would get Medicaid because their disability is significant so they're total care but they don't require Private Duty Nursing, and they can't get Medicaid. And it's really an enormous concern. And I don't think the numbers are that large. But every time we hear about a case, it's really heartbreaking.

This is my last comment. I've heard about a split Medicaid application in the past. Something where you have a child with a disability, another child that's healthy. The assets of the family deemed to the healthy child to allow the child with the disability to get Medicaid. So I've heard it, but it's very nebulous. I actually don't know anyone who's gotten that way. So if that could be considered. That wouldn't work for everybody. It could work perhaps for some, but I just would love to see children with disabilities who need Medicaid to be able to get it.

CHAIRWOMAN SPITALNIK: Thank you.

MS. BRENNAN: Thank you.

CHAIRWOMAN SPITALNIK: Josh.

MR. SPIELBERG: One point of clarification on

the transitioning to HCBS and from HCBS. Where does assisted living fit in? Is that considered HCBS? So if a person transitions from there to a nursing home, they're going from, quote, HCBS or --

MS. BRENNAN: Yes. Assistant living is considered community placement, and that would be included in whichever category.

CHAIRWOMAN SPITALNIK: Thank you.

Phil.

MR. LUBITZ: Hi. Phil Lubitz from NAMI, New Jersey National Alliance on Mental Illness.

I was wondering if we've been able to get beyond process measures and start to look at things like quality of life measures or people who have made this transition, maybe days in hospital, mortality among the two populations. I'm just wondering if we've gotten into any of that.

MS. BRENNAN: We certainly have under the MFP Program, quality follow-up, we do surveys of that population specifically. We will certainly take back the comment about looking particularly at these populations and those measures.

MR. LUBITZ: So will that be available? Quality of life?

MS. BRENNAN: We'll take it back and we'll present next time on it. I can't speak to what's available

at this point off the top of my head.

CHAIRWOMAN SPITALNIK: Noted. Thank you.

Sir?

MR. BROWER: Michael Brower from Disability Rights New Jersey.

I want to comment on a trend that DRNJ noted over the last year. In particular, folks in the IDD population or those with developmental disabilities that are chronic and long-term and have ongoing unchanged needs for Private Duty Nursing, who see a cut come from their MCO who appeal that cut are successful in getting a determination by their external review or at a fair hearing and then within rapid session see another cut and find themselves in a perpetual cycle of having to appeal the level of service that they need even though their condition or their need for service hasn't changed.

I'm joined here today by Kent Hewitt who is a guardian for one such individual. We've had several clients. Ken is the bravest and has asked to come and speak. So if the MAAC would recognize him.

CHAIRWOMAN SPITALNIK: Yes. Very appreciative of your presence, but for brief comment. We would very much like to hear from you. Thank you.

MR. HEWITT: Hello. Thanks for taking the time to hear my comment. I'm the father of Zachary Hewitt. Just

a little brief medical history, he had a stroke when he was 18 days old and had massive damage to two-thirds side of his brain, which causes him to have CP and seizures. So he's got a feeding tube. He's in a wheelchair. He's incontinent. So he's 100 percent cared for 24 hours a day, 7 days a week. He needs skilled nursing care. So we started getting nursing care at 16 years old, so he's 24 now. He has the mentality of a 9-month old. We got our first notice of reduction in hours in May of 2019. We went through the appeal process, got denied. Went through the external appeal process, got it overturned in July. It's a very daunting task to do so. My wife and I both work full-time hours. We have to get several doctors' notes from all of his medical doctors, CP doctors, neurologists, you name it, we have to get it. And it's not a priority to them to get you those notes. So day in and day out, we're constantly calling doctors because you have seven days to file your appeal. If you don't get it, you're cut in hours. It's seven days a week that you're doing this. We file the appeal. We get it overturned. We get our letter in July. Three months go by, we get another notice that they're cutting his hours again. We file again. We ask if we can just use the paperwork and the appeal that we just received from August that we just received. They said no, it's old, his condition has changed. Well, in 24 years, his

condition has never changed from the time he had a stroke. So now the fight starts again. So now we have to go through the daunting paperwork, doctors' notes, levers everything again. It gets denied from the first appeal. Now we're going through our second appeal, going through the external appeal. Now we get it overturned. So now we're good through April, which I don't have any confidence in. Once this is done, we're going to go through this again because now we're on our third. So I'm just asking some kind of change happen. It's not fair to myself or anybody.

CHAIRWOMAN SPITALNIK: Thank you very much. Thank you very much.

Your name, please?

MS. SOLOMON: Kim Solomon with the Community Health Law Project.

I do notice that it does seem like some of the same people are -- they do get the overturned decision and they're getting cut again. So we're seeing that more and more. And I don't know if something could be done because they go after the same person repeatedly.

CHAIRWOMAN SPITALNIK: Thank you.

MS. JACOBS: Thank you.

CHAIRWOMAN SPITALNIK: Gwen.

MS. ORLOWSKI: Thank you.

And thank you very much for coming in and talking

today. I think that was noted. So thank you.

I have two questions on your presentation. Are we able to get the slide back up on nursing facility? Yes, that one. Thank you.

Part of what we have at Protection Advocacy is federal funding around individuals with traumatic brain injury. We actually have our coordinator Susan Head here from our traumatic brain injury program. And we are really trying to do a deep dive into folks in nursing homes who have traumatic brain injuries and whether or not they're getting the services they need there and how they're being assisted to transition back into the community and what we call the TBI track of MLTSS. It used to be a standalone waiver.

So a question I have about these figures is are you able to -- I don't ask this now, but are you able to tease out from those numbers, of that 143, how many of those people went to a TBI group home and are now getting TBI services? I think that that would be really valuable information for some of the work that we're doing around TBI.

And the second thing I just want to say real quickly dovetailing, I think, on something that Bev said about the children who have trouble getting on Medicaid and the split applications. You know, we have one of those than clients right now. And we really think they're appropriate for what I call the middle class Medicaid prong of the CSOC

waiver that has not been operationalized even though it was approved by CMS July 1, 2017. So we have families with children with significant needs who should be on Medicaid. And especially when ADA is going to be a State plan service, it's really critical that they're on that second prong that gets them the whole State Plan as well as PerformCare. And so we'd ask if at a future MAAC meeting we could have that addressed as well.

CHAIRWOMAN SPITALNIK: Thank you.

Lauren.

MS. AGORATUS: Lauren Agoratus, Family Voices.

I just want to go on record as saying we were also one the families denied by UnitedHealthcare, went through the external appeal, and if it weren't for Disability Rights New Jersey, we would have lost our nursing. And they did it to us again as well. Thank you.

CHAIRWOMAN SPITALNIK: Thank you.

Others?

Josh.

MR. SPIELBERG: So just note based on the moving comments by Mr. Hewitt and this problem recurring, I would like to see if there's something that can be done about it so they don't have to be these every six months reviews on Medicaid beneficiaries who are aren't improving. So if that could be addressed at the next meeting, that would be

very helpful.

CHAIRWOMAN SPITALNIK: Thank you.

Yes?

MR. GINSBERG: Lee Ginsberg, Community Health Law Project. Just dovetailing on what people are saying about the PDN denials and cycle of denials, we've actually been seeing -- with Horizon we've been seeing three-month periods with people, again, these are often young adults transitioning from EPSDT to PDN Plus and we've been seeing that three-month periods of review with people with no reasonable chance of improvement and people have not improved. So it's really troubling. And one case in particular with basically three in a row three-month reviews getting overturned by external review in each case, but then again coming back after three months and saying we're going to reduce it again. So it's really a problem.

There also seems to be a problem with Horizon's acuity tool that they use when they look at these cases. Oftentimes, they don't go out and meet with the patient or talk to the caregivers or nurses. They just go by the nursing shift notes and use this acuity tool that the algorithm is not available. So even Horizon doesn't have the algorithm, so they rely on this almost exclusively and often without even talking to the caregivers or the patient. And so it's becoming a big problem. And Horizon, one of

their lawyers has told me that their focus seems to be on the people transitioning from EPSDT to PDN Plus, so these are young adults and they're saying that even though they acknowledge that there's no significant difference in the criteria among those two groups, they're still saying we have to look at them more carefully and that's what we're doing. But, again, it's just happening in a way that's really not good for anybody, I think. And especially the population of people that are not expected to make improvement, which we're seeing also in our organization.

CHAIRWOMAN SPITALNIK: Thank you very much.

MS. JACOBS: I want to thank you everybody for their comments on this. We see and hear a theme coming together here. You have given us some examples. We'll do some work on this over the next couple of months. And the next time we get together for a MAAC meeting, we'll have a report out for you.

CHAIRWOMAN SPITALNIK: Thank you.

Thank you, Liz.

We now turn to some initiatives that are either in the planning or the implementation stage. We'll now address the autism benefit. And I'm pleased to welcome back Steve Tunney who is the Chief of Behavioral Health and Customer Service at DMAHS.

Steve, welcome.

MR. TUNNEY: Thank you.

For those of you who were here at the last one, this slide is pretty familiar. For the autism benefit available today, we have physical therapy, occupational therapy, speech therapy, sensory integration therapy, augmentative and alternative communication devices. Those services are currently available. For the Children System of Care, they've been providing clinical intervention and skill acquisition, capacity building, otherwise called social and emotional learning. So those services have been and will continue to be available.

(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/.)

CHAIRWOMAN SPITALNIK: Thank you.

And can I just clarify? So CMS has approved the State Plan amendment? Or you're anticipating that by April 1st?

MR. TUNNEY: We're anticipating that by April 1st.

CHAIRWOMAN SPITALNIK: Thank you.

Questions?

Mary.

MS. COOGAN: So there was some comments earlier in terms of whether people are aware of the benefits. My sense is a parent has to be looking for benefits, call PerformCare, and then be approved or deemed eligible, correct?

MR. TUNNEY: That's how it stands today. It's going to be through the Managed Care plan, so you would contact the Behavioral Health number on the back of the Managed Care plan card, and then they would be the one that would be authorizing the services, let you know what's available. It will be in their handbook. Just to let you know, for the communication purposes, the children that are currently getting services through DCF, we have a meeting with DCF. We, being the Division of Medical Assistance. We're going to meet with DCF's leadership and discuss how that transition is going to go. We have a meeting set up between PerformCare, who is doing the authorization, and then our Managed Care plans. They're going to get together and then they will discuss what information is needed for a smooth handoff and whatever has to happen, how they'll have that bi-directional referral process that's going to take place, the responsibilities that Carol had mentioned about participating possibly in the CMO family plan, things like that. So that meeting is scheduled, and that will be taking place. And I don't have a date yet, but we plan on having

an open forum where we would invite providers and family members that if they had questions that they could come in. We'll have the managed care plans there, and then we'll good give them that information as well.

MS. COOGAN: You're talking about for the new benefits, right? So I'm assuming the different advocacy groups who are in the audience who help families who have children with autism would be invited to that open session that you're talking about having?

So the groups that actually provide advocacy for families who have children with autism, are they at all part of this process in terms of determining the plan? Or they're just going to hear about this at the open session you're planning on having after it's done?

MR. TUNNEY: Well, we hope to notify them and they would be taking part in that open session that we have. A newsletter is going to go out. So all the providers that we have will be notified through the newsletter. That will primarily be the providers that we have already enrolled through Medicaid through DCA. Additional providers have reached out to our office. And as they come in, we'll get them signed up. I don't know if the Managed Care plans are willing to reach out or provide information as they're trying to sign up providers. But anybody who contacts PerformCare will get referred through the call how to get

the services. We're trying to make sure that there's no wrong door. So if you still go to DCF, they will get you to the Managed Care plan if it's a service that they don't provide and then vice versa.

CHAIRWOMAN SPITALNIK: I want to step out of the role of Chair of the MAAC and speak as a member of the stakeholder workgroup that developed the benefit, and there are others present which is that I think it would behoove Medicaid and the Department of Children and Families to reconvene that stakeholder group to review the processes that have been established, number one. Two, in identifying the pathways to access, that prior even to a stakeholder meeting that families who either use the service or might use the service that there be at least focus group or key informants to reflect on the referral patterns that are inherent in this. Having stakeholder input, as I think Medicaid did very well when the benefit was being proposed, but then there'd be accessible consumer education materials that people can understand their benefits through PerformCare and their benefits as members of a Managed Care organization. And I think that's very much in the spirit that this was launched, but I think there's a benefit. There's the risk of high confusion, and I think it's a very important benefit that we want to have it live up to the State's commitment.

With that, any other questions or comments?

MS. COOGAN: Thank you.

MR. TUNNEY: Let me just say we were planning on revisiting with the original stakeholder group.

CHAIRWOMAN SPITALNIK: Thank you. But I also very much want to reinforce -- and I apologize for repeating myself -- that whatever is developed before, it's really operationalized that there be families at the table who can walk through that with you as a test example about the kinds of confusion and that we assure that there's a diversity of families in terms of language and other considerations. So thank you.

Beverly.

MS. ROBERTS: I absolutely agree. And when it is all operationalized, which I know it's a little bit down the road, but when that happens, hopefully, there will be good information on the website so that it can be accessed by people who have not necessarily been part of the stakeholder process.

MR. TUNNEY: We've already started with FAQs. We planned on distributing them with the newsletter, but there will also be FAQs for individuals that want to go onto the website and get that information.

MS. ROBERTS: Good.

CHAIRWOMAN SPITALNIK: Anything else from the

MAAC?

Anything from the public?

Yes?

MR. KRAMER: Bill Kramer, Morris County Caregivers Coalition.

For caregivers, could you sort of translate EPSDT?

MS. JACOBS: Early Periodic Screening Diagnosis and Treatment. It's shorthand for the federal entitlement for young children preventive care, et cetera.

CHAIRWOMAN SPITALNIK: And it goes 0 to 21.

Any other acronyms to bust or any other considerations?

Yes?

MS. ADAMS: So the question that I brought up before as far as the collaboration between --

CHAIRWOMAN SPITALNIK: Your name, please?

MS. ADAMS: I'm sorry. Hannah Adams. We service children with autism.

So many families are definitely getting very excited about this new development. And I'm just wondering about this required collaboration between the ABA providers and, let's say, PerformCare or whatever is come from CSOC. Is there a system in place of how that's going to work so that if you have members who are currently not getting

services or currently have a PerformCare services of how that collaboration is going to work so that things can kind of get in smoothly and how it's going to work, like, if there were authorizations as far dividing how the hours should be allocated between the ABA and what's coming from DCF or CSOC? Is that going to be worked completely separately, or are there going to be case managers that are going to be helping with that collaboration? That was my first question.

CHAIRWOMAN SPITALNIK: I just want to restate that. So the question is are there or will there be mechanisms between coordination between services provided by PerformCare and services provided by the Managed Care Organization? Is that the first question?

MS. ADAMS: Yes.

CHAIRWOMAN SPITALNIK: Thank you. Your second question?

MS. ADAMS: My second question is currently there are CMS rates for ABA services. Like, if you check it on the CMS website, it says that it's based on per Managed Care Organization. So as contracts are being written, each MCO is putting in whatever their rates are. Is that something that's going to change and is CMS going to create rates that are going to become standard across all the HMOs, or is it going to continue to be individual to each one?

CHAIRWOMAN SPITALNIK: Thank you.

MS. JACOBS: I can take that. I think I have both questions in my head.

The first question was about coordination with the services that are provided through CSOC and services provided through Managed Care.

CHAIRWOMAN SPITALNIK: Excuse me. Children System of Care in the Department of Children and Families.

MS. JACOBS: Thank you. 2020 will be the year of acronym busting. Thank you.

So ideally, you wouldn't need to do this through two venues; you would just do it through one, and that would make it a lot simpler. This is not a perfect world. And so the infrastructure that exists at the Children System of Care is important. Families are already tapping it. It wouldn't make sense to replicate it specifically for Medicaid. So we do this now kind of two ways. We have the services that families are accessing through that existing program and then some additional services that they'll access through Medicaid Managed Care. Depending on their child's particular needs, they may have a care manager already through the Children's System of Care. That same kid may also have a care manager within their Managed Care plan. And we want to make sure that those care managers are talking to each other because we saw the need to keep these two pieces of our program, but we also saw the need to have

them be coordinated and tied together in the way that you're describing. So when Carol talked earlier about the contract language that we added around the autism benefit, we were very specific in saying that we expected the health plans to make those connections at the Children System of Care so that we're as coordinated as we can possibly be in those two different pieces of the program. I believe that that will be something that requires continuous improvement, as is always true in our program. So as a community, we will work together on that. But that is the intention, that the health plans will work very closely with the Children's System of Care so that everybody's talking to each other about this child's services and their specific individual needs.

The next question was about rates. And so I'll just briefly answer you to say we will establish a set of New Jersey Medicaid Fee For Service rates, and the health plans will sometimes reference those in their negotiations with providers. But the negotiations of the health plans as they're building their autism networks are not required to include those Fee For Service rates that we have establish. So we have not yet set our rates. The health plans are out building their networks. You'll see all of that kind of happening at the same time, but I didn't want you to have the sense that the health sense would be

necessarily right on the rates that we are on.

CHAIRWOMAN SPITALNIK: Thank you.

MR. TUNNEY: Can I just clarify?

CMS rates are Medicare rates, so unless Medicare decides to cover ABA services, you won't see a rate put in there for that.

And then the other part I think you were asking, whatever they do at DCF, Department of Children and Families, through the Children System of Care and what the plans are doing, they're not one or the other. So they may work together. I don't want you to think that it's getting together to decide, all right, you can provide the service and I won't. Whatever service you need, they're going to get. They're just going to work together in terms of sharing information and maybe some services are kind of adjunctive to another service and they can benefit from having both. But I don't want you to think that it's going to be an elimination of anything. It's not one or the other.

CHAIRWOMAN SPITALNIK: Thank you. I'm sorry, I'm going to stop the discussion here and look towards if there's anyone else who wants to make a comment or a question.

MS. GRANT: I only wanted to add something to this.

CHAIRWOMAN SPITALNIK: Please.

MS. GRANT: I want it to be clear that as this transition happens, there will be requirements around continuity of care so that nobody falls through the cracks. Whatever has already been decided or assessed, as people come over the Managed Care will be maintained unless there's a need to do another assessment. This is normally how we do business, and we would ask people to make sure, as we will, that this actually happens.

CHAIRWOMAN SPITALNIK: Thank you so much for that clarification.

Anything else?

Steve, thank you. And we look forward to reconvening and to bringing this forward on the next agenda in April.

We're now going to hear about the doula care benefits from Jen Jacobs.

MS. JACOBS: Greg Woods, our Chief of Innovation, was going to present these slides to you today. Unfortunately, he got called away. For those of you who know Greg, he's about a foot and a half taller than I am, so I told him that I would wear my tallest heels and see if I could convince you that I was him.

I wanted to talk to you about doulas today. I think many of you are aware that we are rolling this benefit out in New Jersey Medicaid as part of the First Lady's

Maternal Child Health Initiatives. We are really excited about this benefit because it addresses in a very targeted way what we know to be tremendous disparities, tremendous unacceptable disparities in how women of color and their babies experience our health care system. And in particular, for an African-American mom, the risk of serious issues after delivering her baby is three times higher than the risk of other moms. And the risk of that baby dying is also significantly higher. We cannot get out of bed each day and go to work without considering that reality and what we can possibly do about it.

So doulas are a part of the picture, not the whole picture, but they are an important part of the picture because what they represent is prenatal care, postpartum care, and labor and delivery care that is nonclinical that supports that mom through that entire experience. And so when you think about, well, what kind of nonclinical support do women need, we're really taking about understanding how to navigate the healthcare system. These are women who may be Medicaid eligible, for example, for the first time. They may be having a baby for the first time. They may not have had proper OB care now that they're pregnant until meeting up with this doula or becoming Medicaid eligible. They may have traumatic history that needs to be considered that would be part of the picture here. And so the role the doula

can play is pulling together these nonclinical pieces in a way that clinicians might not. Some really great clinicians will, but not all clinicians will. And so the doula plays a role as a wise advocate for that mom, and we want to be supportive of that concept. There's evidence that says this really may move the needle in our communities, and so we want to do that the best way possible and see what happens.

So we have been meeting with a group of doulas from all over the State since about six months ago, I guess. And in the process of those discussions, we've said to them talk to us about the work that you do with moms and their babies today, talk to us about what best practice looks like in your field, talk to us about the obstacles that you encounter. And in particular, we've looked at what we refer to as technical change and adaptive change. And probably we'll talk to you using those terms at some point again in a future, so just to explain briefly, technical change is figuring out how legally and logistically we can get something done and then checking the box and saying we did it; adaptive change is getting to the hearts and minds that will make it successful.

So merely applying to the federal government and saying we would like the authority to put a doula benefit in our program will not actually make that doula benefit

successful. Partnering with our doulas, partnering with our stakeholders in this room, building relations, for example, at hospitals and at OB clinics, that will help us make our doula program successful.

So we're focused both on the technical change that's needed. We're doing a lot of that block and tacking right now and then also on the adaptive change, the hearts and minds piece. And we're working very closely with the Department of Health to get that done.

We recently brought the Managed Care Organizations into the discussion. They're a little bit new at the doula table. But they were collaborative and supportive with us, and we appreciate their patience as we're figuring that. It may surprise you to know that some of our Managed Care Organizations actually already have experience with doula programs in other states, so we're looking to draw from some of that experience as we move forward.

You can imagine that when you're creating something out of nothing, there are about 1,948 different details you have to figure out, and so we're in the process of working through those details right now and doing that in very close partnership with the doulas so that we're able to maintain what I would call the organic nature of this program. In particular, the doulas that we're talking to

are what you call community doulas. So they are folks who, as a rule, live in the community that they serve. They value that. It's very high priority from their point of view. It makes sense to us, too. And we want to also make sure that we are providing a lot of access. So figuring out the best way to ensure that the doulas we're bring into our Medicaid program are appropriately trained to serve the community that we serve, that's an important piece that we'll be working through with the doulas and the Department of Health.

CHAIRWOMAN SPITALNIK: Thank you so much.

Any questions or comments from the MAAC?

From the public?

Yes?

[MS. BUCKLA]: Lucia Buckla.

Is the doula care a service that's covered under presumptive eligibility for pregnant women? Or do we have to be fully approved by Medicaid in order to receive that type of service?

MS. JACOBS: That's a good question. Thanks for asking it. We'll provide the doula service for all of our Medicaid members who are pregnant.

MS. [BUCKLA]: So does that include as well mothers who are undocumented?

MS. JACOBS: All of our Medicaid eligible

members.

MS. [BUCKLA]: Has there been discussions to extend that service to undocumented mothers who only have coverage for labor and delivery?

MS. JACOBS: Let me be very specific. If they're covered with Medicaid for their birth as a pregnant woman, they will have access to this service. There are also doula services being provided to women who are giving birth without Medicaid coverage. But our Medicaid coverage will offer this doula service regardless of who you are, as long as you're pregnant.

CHAIRWOMAN SPITALNIK: Thank you.

Seeing that there are no immediate questions about the doula care benefit, Jen, would you stay at the podium and give us the information about the electronic visit verification?

MS. JACOBS: Yes. Generally, I have a rule not to talk about federal mandates on an empty stomach, so I will do my best to get us all out of here quickly since I think we're close to done.

Just to give folks a sense if you're not familiar with it already and so if I'm repeating this for some of you, please forgive me. Electronic visit verification is technology that allows us to know when a home health aide is arriving in a member's home, what services they're

providing while they are there, and when they leave. And it should tie to both payroll and billing.

As you can imagine, a service that tracks someone entering and leaving your home could be a bit controversial. It also could be very valuable in the sense of right now today we don't know when that aid does or doesn't show up. We don't have real-time data on that. So we looked at concerns we've heard around privacy and the ability to set schedules, particularly within self-directed services, and we hear those concerns. We also see the value of the data that we will have tomorrow that we don't have today. This is a federal mandate, and so however we feel about the technology that we're talking about, we will be rolling it out here in New Jersey. It was a federal mandate for January 1st of 2020. New Jersey requested a good-faith exemption from that January 1st requirement, and we received that good-faith waiver from the federal government so that we could kick off a little bit later in the year. So let me talk to you about that a little bit. Let me put a slide up for you.

(Slide presentation by Ms. Jacobs.)

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

CHAIRWOMAN SPITALNIK: Thank you.

Comments or questions from the MAAC?

Beverly.

MS. ROBERTS: Thank you very much, Jen.

Very quick question. So you say said you expect a vendor is going to be selected very soon and then you said go-live in six months. But if it turns out that you select a vendor March 1st, could you delay go-live beyond six months since you actually have until December 31st?

MS. JACOBS: Thank you for asking for that clarification. The RFP specifically says that we will go-live six months from the date of selection. So that's the expectation. So, for example, if the vendor was selected on March 1st, then we would be expected to go-live on September 1st.

MS. ROBERTS: Would there be any possibility if you wanted to have a little bit more of an extension to do that?

MS. JACOBS: I think there's always a possibility, but there's also always a risk. And the risk of extending any further is we don't have any testing zone between our launch and the real deal. So we'll have to have that discussion. If it came down to it, we could go to DPP and say, do we have flexibility around this six months, I wouldn't take that off the table. But I would be mindful

about what happens if we go all the way up to the last minute.

MS. ROBERTS: And one other question. Are you expecting to start out in some sort pilot way? Like you just said, start it and what might be the kinks. Are you expecting go-live will be statewide or it could be potentially a smaller pilot?

MS. JACOBS: Candidly, we haven't had that discussion.

CHAIRWOMAN SPITALNIK: Anything else from the MAAC?

Anything from the public about electronic visit verification?

Yes?

MS. MARINARO: I have two questions. I don't know anything about this, and I want to learn more.

One, are there any states that you know that are doing this now that you can look at and go like, oh, they're doing it, how is it going? Is there any state that has implemented EV?

MS. JACOBS: Yes. And we're watching a few. I will give you a couple of examples of what we're watching. I have to look to Florida because I was part of the implementation down there before I moved to New Jersey six months ago. I moved back to New Jersey, I should say, six months ago. So we're watching what's going on there. And

then the other state I'll give you as an example is Pennsylvania because they have been very coordinated about this. And they had planned on launching earlier. They took a little sort of leeway there. And we'll be seeing how they do it as well.

MS. MARINARO: Thank you. My second question was this applies to all PCA? And does it not apply to PDN? Does it not apply to other --

MS. JACOBS: Good question. PCA, including self-direction, so a lot of members and a lot of providers -- a lot of members, a lot of aides, right? Everybody's got to be trained on how to do. There will be some complexity to that. If I remember correctly, the law also speaks to skilled visits, but they were a couple years down the road and I don't know what has happened in that language because I've been so focused on this. But we can provide an update for you on that. The federal rule does require the skilled visits to be incorporated in EVV. It was a date after the non-skilled visits.

CHAIRWOMAN SPITALNIK: Thank you.

Anything else?

Thank you very much.

And as we get close to our time of gratitude for a very robust meeting, both in terms of presentation and participation, I will now attempt to recap what we've

identified for our next meeting or follow-up for the April meeting:

A progress report around the transitions in eligibility.

The Division of Developmental Disabilities agreed to provide a flow chart in terms of eligibility and the role of support coordinators.

Jen Jacobs made the invitation to look at specific cases where individuals are no longer able to access their care through hospitals.

The issue of having an ombudsman in place around initial corrective action issues, having access to information.

There was also in relationship to contract changes, the definitions of community-based care management.

We had also agreed, and this will happen this afternoon, the information from the Department of Health will be posted on the DMS website and linked to the Department of Health.

There was very comprehensive interest and concern and the need to do a deeper dive on Private Duty Nursing within MLTSS, the issues of the requirements for continued approvals and denials, the issue of the split application and Medicaid eligibility for people who don't

meet the income requirement.

This is not all going to happen in April or we ought to have a barbecue for July 4th, but there was also expressed the interest in tracking the transitions from nursing facilities to HCBS services for people with traumatic brain injury.

The transitions from EPSDT to adult services for young adults who do not demonstrate significant improvement.

The importance of clarity and information around the new autism State Plan amendment.

And then a follow-up on the electronic visit verification.

Anything else?

Okay, let me remind us that our next meeting is also at this location on Wednesday, April 22nd. Subsequently, we have a meeting on July 22nd, and then October 21st.

Again, thank you for all the preparation. Thank you, Lisa Bradley, for your notes.

And do I have a motion to adjourn?

MS. ROBERTS: Motion to adjourn.

MS. COOGAN: Second.

CHAIRWOMAN SPITALNIK: We are adjourned. Thank you all.

(Meeting adjourned at 12:57 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 non-compressed transcript of the proceedings as recorded.

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Lisa C. Bradley, CCR

The Scribe